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: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/27/2012 12:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/27/2012 Time: 12:05 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 MERCER COUNTY HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title 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	-47,603	63,373	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	-96,734	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	0	0		0	7.00
8.00	Nursing Facility	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-21,126		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	-144,337	42,247	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/27/2012 12:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	MERCER COUNTY HOSPITAL	141304	19340	1	05/01/2000	N	O	O	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	MERCER COUNTY HOSPITAL	14Z304	19340		05/01/2000	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MERCER COUNTY HOSPITAL	147462	19340		01/06/1987	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MERCER COUNTY HOSPITAL	141593	19340		09/05/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	MERCER COUNTY HOSPITAL	143453	19340		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, 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.	0	35.00

		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00

H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm

		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm

		V	XIX	
		1.00	2.00	
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	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.	N		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.	5,000,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05101	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box: 0		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm

		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: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/27/2012 12:04 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)	Y			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	10/18/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A			
		Description	Y/N	Date		
		0	1.00	2.00		
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	12/01/2011		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: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/27/2012 12:04 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/27/2012 12:04 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	12/01/2011	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: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 12:04 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	22	8,030	13,947.00		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)		22	8,030	13,947.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	13,947.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		22				27.00
28.00	Observation Bed Days						28.00
28.02	SUBPROVIDER - IRF	41.00					28.02
28.03	SUBPROVIDER	42.00					28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 12:04 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	498	41	676		1.00
2.00	HMO		44	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	743	0	791		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	14		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,241	41	1,481		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	1,241	41	1,481		14.00
15.00	CAH visits	0	8,798	2,706	20,576		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0		17.00
18.00	SUBPROVIDER	0	0	0	0		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	3,547	177	4,585		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	3,961	4,110	15,318		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		51	404		28.00
28.02	SUBPROVIDER - IRF	0	0	0	0		28.02
28.03	SUBPROVIDER	0	0	0	0		28.03
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 12:04 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	169	1.00
2.00	HMO					17	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	93.04	0.00	0	169	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00	SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	4.92	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	0.55	0.00			24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	10.22	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	108.73	0.00			27.00
28.00	Observation Bed Days						28.00
28.02	SUBPROVIDER - IRF						28.02
28.03	SUBPROVIDER						28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 12:04 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)	14	243		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)	14	243		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF	0	0		17.00
18.00	SUBPROVIDER	0	0		18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.02	SUBPROVIDER - IRF				28.02
28.03	SUBPROVIDER				28.03
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141304 | Component CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-4 | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		1.00	
0.00	County	MERCER	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	832	4	73	909	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	116.00	6.00	29.00	151.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			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	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.39	0.00	2.39	5.00
6.00	Direct Nursing Service		2.42	0.00	2.42	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.36	0.00	1.36	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).		19340			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	1,415	249	78	6	1,748	21.00
22.00	Skilled Nursing Visit Charges	395,351	68,977	21,861	1,664	487,853	22.00
23.00	Physical Therapy Visits	299	2	0	0	301	23.00
24.00	Physical Therapy Visit Charges	37,511	252	0	0	37,763	24.00
25.00	Occupational Therapy Visits	96	0	0	0	96	25.00
26.00	Occupational Therapy Visit Charges	13,028	0	0	0	13,028	26.00
27.00	Speech Pathology Visits	3	0	0	0	3	27.00
28.00	Speech Pathology Visit Charges	378	0	0	0	378	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	1,322	71	6	0	1,399	31.00
32.00	Home Health Aide Visit Charges	75,233	4,042	343	0	79,618	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,135	322	84	6	3,547	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	521,501	73,271	22,204	1,664	618,640	35.00
36.00	Total Number of Episodes (standard/non outlier)	181		28	1	210	36.00
37.00	Total Number of Outlier Episodes		6		0	6	37.00
38.00	Total Non-Routine Medical Supply Charges	7,893	981	1,011	0	9,885	38.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-8 | Date/Time Prepared: 1/27/2012 12:04 pm

				Rural Health Clinic (RHC) I	Cost
				1.00	
	Clinic Address and Identification				
1.00	Street			1007 NW 3RD STREET	1.00
		City		State	Zip Code
		1.00		2.00	3.00
2.00	City, State, Zip Code, County	ALEDO		IL	61231 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			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.			N	0 13.00
				Provider name	CCN number
				1.00	2.00
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		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: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 12:04 pm
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	MERCER					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: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 12:04 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: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 12:04 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 141304 Component CCN: 141593	Period: From 07/01/2010 To 06/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 1/27/2012 12:04 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	1,941	0	0	0	50	2.00
3.00	Inpatient Respite Care	13	0	0	0	5	3.00
4.00	General Inpatient Care	9	0	0	0	0	4.00
5.00	Total Hospice Days	1,963	0	0	0	55	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	36	0	0	0	7	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)	54.53	0.00	0.00	0.00	7.86	8.00
9.00	Unduplicated Census Count	36	0	0	0	7	9.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 141304 Component CCN: 141593	Period: From 07/01/2010 To 06/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 1/27/2012 12:04 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	1,991		2.00
3.00	Inpatient Respite Care	18		3.00
4.00	General Inpatient Care	9		4.00
5.00	Total Hospice Days	2,018		5.00
	Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	43		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)	46.93		8.00
9.00	Unduplicated Census Count	43		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/27/2012 12:04 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)	0.613647	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	155,452	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	2,258,602	6.00
7.00	Medicaid cost (line 1 times line 6)	1,385,984	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)	1,230,532	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	8,000	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)	1,230,532	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	398,268	0	398,268	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	244,396	0	244,396	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)	244,396	0	244,396	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	447,265	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	88,409	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	358,856	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	220,211	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	464,607	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,695,139	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/27/2012 12:04 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		89,336	89,336	133,669	223,005	1.00
1.01	FOUNDATION BLDG		0	0	74,490	74,490	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		322,815	322,815	86,347	409,162	2.00
3.00	OTHER CAPITAL RELATED COSTS		186,030	186,030	-186,030	0	3.00
4.00	EMPLOYEE BENEFITS	98,241	1,181,262	1,279,503	0	1,279,503	4.00
5.01	ADMITTING	98,411	13,389	111,800	0	111,800	5.01
5.02	A&G HOSPITAL ONLY	333,370	132,236	465,606	17,518	483,124	5.02
5.03	SHARED ADMIN & GENERAL	142,240	653,296	795,536	128,064	923,600	5.03
6.00	MAINTENANCE & REPAIRS	135,825	128,566	264,391	0	264,391	6.00
7.00	OPERATION OF PLANT	0	284,054	284,054	0	284,054	7.00
8.00	LAUNDRY & LINEN SERVICE	4,031	35,019	39,050	0	39,050	8.00
9.00	HOUSEKEEPING	73,029	30,326	103,355	0	103,355	9.00
10.00	DIETARY	153,130	112,318	265,448	0	265,448	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	97,009	8,222	105,231	0	105,231	13.00
14.00	CENTRAL SERVICES & SUPPLY	5,415	36,312	41,727	0	41,727	14.00
16.00	MEDICAL RECORDS & LIBRARY	77,535	104,386	181,921	0	181,921	16.00
17.00	SOCIAL SERVICE	51,486	4,265	55,751	0	55,751	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	152,553	152,553	0	152,553	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	816,819	123,184	940,003	0	940,003	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	62,809	71,373	134,182	0	134,182	50.00
53.00	ANESTHESIOLOGY	0	157	157	0	157	53.00
54.00	RADIOLOGY-DIAGNOSTIC	392,529	251,463	643,992	118,996	762,988	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	397,945	643,633	1,041,578	-41,013	1,000,565	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	41,013	41,013	63.00
65.00	RESPIRATORY THERAPY	138,611	105,281	243,892	0	243,892	65.00
66.00	PHYSICAL THERAPY	269,562	37,403	306,965	0	306,965	66.00
67.00	OCCUPATIONAL THERAPY	0	40,244	40,244	0	40,244	67.00
68.00	SPEECH PATHOLOGY	0	9,060	9,060	0	9,060	68.00
69.00	ELECTROCARDIOLOGY	0	155,376	155,376	-118,996	36,380	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	177,233	324,619	501,852	0	501,852	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,048,152	700,598	1,748,750	-138,688	1,610,062	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	171,259	87,879	259,138	0	259,138	90.00
91.00	EMERGENCY	417,756	786,583	1,204,339	0	1,204,339	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	322,786	97,819	420,605	-32,139	388,466	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE		83,231	83,231	-83,231	0	113.00
116.00	HOSPICE	41,933	43,208	85,141	0	85,141	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,527,116	7,035,496	12,562,612	0	12,562,612	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	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	5,527,116	7,035,496	12,562,612	0	12,562,612	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/27/2012 12:04 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	0	223,005		1.00
1.01	FOUNDATION BLDG	-21,328	53,162		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-70	409,092		2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-2,113	1,277,390		4.00
5.01	ADMITTING	0	111,800		5.01
5.02	A&G HOSPITAL ONLY	0	483,124		5.02
5.03	SHARED ADMIN & GENERAL	341,477	1,265,077		5.03
6.00	MAINTENANCE & REPAIRS	0	264,391		6.00
7.00	OPERATION OF PLANT	0	284,054		7.00
8.00	LAUNDRY & LINEN SERVICE	0	39,050		8.00
9.00	HOUSEKEEPING	0	103,355		9.00
10.00	DIETARY	-71,066	194,382		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	105,231		13.00
14.00	CENTRAL SERVICES & SUPPLY	-889	40,838		14.00
16.00	MEDICAL RECORDS & LIBRARY	-23,141	158,780		16.00
17.00	SOCIAL SERVICE	0	55,751		17.00
19.00	NONPHYSICIAN ANESTHETISTS	-152,553	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	940,003		30.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-327	133,855		50.00
53.00	ANESTHESIOLOGY	0	157		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-1,420	761,568		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	-2,259	998,306		60.00
60.01	BLOOD LABORATORY	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	41,013		63.00
65.00	RESPIRATORY THERAPY	-34,351	209,541		65.00
66.00	PHYSICAL THERAPY	0	306,965		66.00
67.00	OCCUPATIONAL THERAPY	-388	39,856		67.00
68.00	SPEECH PATHOLOGY	0	9,060		68.00
69.00	ELECTROCARDIOLOGY	-14,584	21,796		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	-176,428	325,424		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-76,959	1,533,103		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	-201,503	57,635		90.00
91.00	EMERGENCY	-102,210	1,102,129		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0		95.00
99.10	CORF	0	0		99.10
101.00	HOME HEALTH AGENCY	-20	388,446		101.00
	SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0		110.00
111.00	ISLET ACQUISITION	0	0		111.00
113.00	INTEREST EXPENSE	0	0		113.00
116.00	HOSPICE	0	85,141		116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-540,132	12,022,480		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	BOARD OF HEALTH	0	0		194.00
194.01	VACANT PHYSICIAN OFFICE	0	0		194.01
194.02	JAIL MEALS	0	0		194.02
194.03	KIDNEY CENTER	0	0		194.03
200.00	TOTAL (SUM OF LINES 118-199)	-540,132	12,022,480		200.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/27/2012 12:04 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	69,972		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	13,259		2.00
	TOTALS		0	83,231		
	B - MRI					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	118,996		1.00
	TOTALS		0	118,996		
	C - RENT PAID TO FOUNDATION					
1.00	FOUNDATION BLDG	1.01	0	74,490		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	74,490		
	D - RHC AND HHA SALARY					
1.00	A&G HOSPITAL ONLY	5.02	17,518	0		1.00
2.00	SHARED ADMIN & GENERAL	5.03	87,819	0		2.00
	TOTALS		105,337	0		
	E - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	8,283	32,730		1.00
	TOTALS		8,283	32,730		
	F - MALPRACTICE INSURANCE					
1.00	SHARED ADMIN & GENERAL	5.03	0	49,245		1.00
	TOTALS		0	49,245		
500.00	Grand Total: Increases		113,620	358,692		500.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/27/2012 12:04 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	83,231	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	83,231			
	B - MRI						
1.00	ELECTROCARDIOLOGY	69.00	0	118,996	0		1.00
	TOTALS		0	118,996			
	C - RENT PAID TO FOUNDATION						
1.00	SHARED ADMIN & GENERAL	5.03	0	9,000	9		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	65,490	0		2.00
	TOTALS		0	74,490			
	D - RHC AND HHA SALARY						
1.00	RURAL HEALTH CLINIC	88.00	73,198	0	0		1.00
2.00	HOME HEALTH AGENCY	101.00	32,139	0	0		2.00
	TOTALS		105,337	0			
	E - BLOOD						
1.00	LABORATORY	60.00	8,283	32,730	0		1.00
	TOTALS		8,283	32,730			
	F - MALPRACTICE INSURANCE						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	49,245	0		1.00
	TOTALS		0	49,245			
500.00	Grand Total: Decreases		113,620	358,692			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 12:04 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	43,583	0	0	0	0	1.00
2.00	Land Improvements	24,966	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,829,569	2,872	0	2,872	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,394,187	96,138	95,785	191,923	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,292,305	99,010	95,785	194,795	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,292,305	99,010	95,785	194,795	0	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	89,336	0	0	0	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	322,744	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	412,080	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	3,829,569	0	3,829,569	0.465672	63,697	1.00
1.01	FOUNDATION BLDG	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,394,187	0	4,394,187	0.534328	73,088	2.00
3.00	Total (sum of lines 1-2)	8,223,756	0	8,223,756	1.000000	136,785	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 12:04 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	43,583	0				1.00
2.00	Land Improvements	24,966	0				2.00
3.00	Buildings and Fixtures	3,832,441	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,586,110	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	8,487,100	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	8,487,100	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	89,336				1.00
1.01	FOUNDATION BLDG	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	71	322,815				2.00
3.00	Total (sum of lines 1-2)	71	412,151				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	63,697	159,308	0	1.00
1.01	FOUNDATION BLDG	0	0	0	53,162	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	73,088	335,933	0	2.00
3.00	Total (sum of lines 1-2)	0	0	136,785	548,403	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 12:04 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	0	63,697	0	0	223,005	1.00
1.01	FOUNDATION BLDG	0	0	0	0	53,162	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	73,088	0	71	409,092	2.00
3.00	Total (sum of lines 1-2)	0	136,785	0	71	685,259	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 12:04 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)		0	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)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-263,213			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	334,775			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests		0		0.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - 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	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	SERVICE CHARGE REVENUE	B	-31,392	SHARED ADMIN & GENERAL	5.03	33.00
34.00	CAFETERIA REVENUE	B	-66,201	DIETARY	10.00	34.00
35.00	MISC REV - DIET	B	-2,236	DIETARY	10.00	35.00
36.00	VENDING REVENUE	B	-2,629	DIETARY	10.00	36.00
37.00	MISC REV - MED RECORDS	B	-6,068	MEDICAL RECORDS & LIBRARY	16.00	37.00
38.00	MISC REV - PHARMACY	B	-181,577	DRUGS CHARGED TO PATIENTS	73.00	38.00
39.00	MISC REV - LAB	B	258	LABORATORY	60.00	39.00
40.00	MISC REV - CARDIO	B	-74	RESPIRATORY THERAPY	65.00	40.00
41.00	MISC REV - SUPPLIES	B	-889	CENTRAL SERVICES & SUPPLY	14.00	41.00
42.00	MISC REV - HHA	B	-30	HOME HEALTH AGENCY	101.00	42.00
43.00	RENTAL REVENUE	B	-7,110	RURAL HEALTH CLINIC	88.00	43.00
44.00	MISC INCOME - OTHER REV	B	-8,496	SHARED ADMIN & GENERAL	5.03	44.00
45.00	VENDOR REBATES	B	-14,301	SHARED ADMIN & GENERAL	5.03	45.00
45.01	OFFSET EX UNSHELT BOND SINK	A	-70	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.01
45.02	PATIENT PHONES SALARY	A	-327	SHARED ADMIN & GENERAL	5.03	45.02
45.03	PATIENT PHONES BENEFITS	A	-90	EMPLOYEE BENEFITS	4.00	45.03
45.04	PATIENT PHONES COST	A	-1,268	SHARED ADMIN & GENERAL	5.03	45.04
45.05	LOBBYING EXPENSE	A	-6,256	SHARED ADMIN & GENERAL	5.03	45.05
45.06	ADVERTISING	A	-24,432	SHARED ADMIN & GENERAL	5.03	45.06

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 12:04 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	
45.07	ADVERTISING	A	-379	CLINIC	90.00	45.07
45.08	ADVERTISING	A	-559	LABORATORY	60.00	45.08
45.09	ADVERTISING	A	-3,205	RURAL HEALTH CLINIC	88.00	45.09
45.10	ADVERTISING	A	-38	HOME HEALTH AGENCY	101.00	45.10
45.11	COUNTRY CLUB MEMBERSHIP	A	-311	SHARED ADMIN & GENERAL	5.03	45.11
45.12	CRNA FEES AFTER 1/1/07	A	-152,553	NONPHYSICIAN ANESTHETISTS	19.00	45.12
45.13	AUXILIARY EXPENSE	A	-90	SHARED ADMIN & GENERAL	5.03	45.13
45.14	PODIATRY SERVICES	A	-101,371	CLINIC	90.00	45.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-540,132			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 12:04 pm

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	0		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	SERVICE CHARGE REVENUE	0		33.00
34.00	CAFETERIA REVENUE	0		34.00
35.00	MISC REV - DIET	0		35.00
36.00	VENDING REVENUE	0		36.00
37.00	MISC REV - MED RECORDS	0		37.00
38.00	MISC REV - PHARMACY	0		38.00
39.00	MISC REV - LAB	0		39.00
40.00	MISC REV - CARDIO	0		40.00
41.00	MISC REV - SUPPLIES	0		41.00
42.00	MISC REV - HHA	0		42.00
43.00	RENTAL REVENUE	0		43.00
44.00	MISC INCOME - OTHER REV	0		44.00
45.00	VENDOR REBATES	0		45.00
45.01	OFFSET EX UNSHELT BOND SINK	9		45.01
45.02	PATIENT PHONES SALARY	0		45.02
45.03	PATIENT PHONES BENEFITS	0		45.03
45.04	PATIENT PHONES COST	0		45.04
45.05	LOBBYING EXPENSE	0		45.05
45.06	ADVERTISING	0		45.06
45.07	ADVERTISING	0		45.07
45.08	ADVERTISING	0		45.08
45.09	ADVERTISING	0		45.09
45.10	ADVERTISING	0		45.10
45.11	COUNTRY CLUB MEMBERSHIP	0		45.11
45.12	CRNA FEES AFTER 1/1/07	0		45.12
45.13	AUXILIARY EXPENSE	0		45.13
45.14	PODIATRY SERVICES	0		45.14

ADJUSTMENTS TO EXPENSES	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8 Date/Time Prepared: 1/27/2012 12:04 pm

		Wkst. A-7 Ref.		
		5.00		
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/27/2012 12:04 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.01	FOUNDATION BLDG	RENT EXPENSE	1.00
2.00		67.00	OCCUPATIONAL THERAPY	GMC ILLINI REHAB - OT SERVICES	2.00
3.00		5.03	SHARED ADMIN & GENERAL	GHS - MANAGEMENT SERVICES	3.00
4.00		5.03	SHARED ADMIN & GENERAL	GHS - IT FEES	4.00
4.01		16.00	MEDICAL RECORDS & LIBRARY	GHS - HIM FEES	4.01
4.02		88.00	RURAL HEALTH CLINIC	GHS - GHG CLINIC	4.02
4.03		5.03	SHARED ADMIN & GENERAL	GMC - SUPPLIES	4.03
4.04		50.00	OPERATING ROOM	GMC - SUPPLIES	4.04
4.05		91.00	EMERGENCY	GMC - SUPPLIES	4.05
4.06		101.00	HOME HEALTH AGENCY	GMC - SUPPLIES	4.06
4.07		65.00	RESPIRATORY THERAPY	GMC - SLEEP LAB	4.07
4.08		67.00	OCCUPATIONAL THERAPY	GMC - OT SERVICES	4.08
4.09		73.00	DRUGS CHARGED TO PATIENTS	GMC - PHARMACY SERVICES	4.09
4.10		4.00	EMPLOYEE BENEFITS	GENESIS EAP	4.10
4.11		5.03	SHARED ADMIN & GENERAL	GHS - MARKETING	4.11
4.12		60.00	LABORATORY	GENESIS OCC HLTH - DRUG SCRN	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		A	MERCER CTY HOSP	100.00		6.00
7.00		B	MERCER CTY HOSP	0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-1 | Date/Time Prepared: 1/27/2012 12:04 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		53,162	74,490	-21,328	9		1.00
2.00		3,330	3,330	0	0		2.00
3.00		543,162	240,000	303,162	0		3.00
4.00		228,006	100,000	128,006	0		4.00
4.01		20,682	37,755	-17,073	0		4.01
4.02		138,504	160,000	-21,496	0		4.02
4.03		182	0	182	0		4.03
4.04		657	984	-327	0		4.04
4.05		98	0	98	0		4.05
4.06		48	0	48	0		4.06
4.07		22,523	56,800	-34,277	0		4.07
4.08		3,042	3,430	-388	0		4.08
4.09		5,149	0	5,149	0		4.09
4.10		0	2,023	-2,023	0		4.10
4.11		0	3,000	-3,000	0		4.11
4.12		0	1,958	-1,958	0		4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,018,545	683,770	334,775			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		MERCER FOUNDATION FOR HTL	0.00	NOT-FOR PROFIT	6.00
7.00		GENESIS HLTH SY	0.00	NOT-FOR PROFIT	7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 12:04 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	718,702	102,308	1.00
2.00		88.00	RURAL HEALTH CLINIC	276,021	45,148	2.00
3.00		69.00	ELECTROCARDIOLOGY	14,584	14,584	3.00
4.00		54.00	RADIOLOGY-DIAGNOSTIC	1,420	1,420	4.00
5.00		90.00	PODIATRY CLINIC	99,753	99,753	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,110,480	263,213	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 12:04 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		616,393	0	0	0	0	1.00
2.00		230,873	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		847,266		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 12:04 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	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-2 Date/Time Prepared: 1/27/2012 12:04 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	102,308		1.00
2.00		0	45,148		2.00
3.00		0	14,584		3.00
4.00		0	1,420		4.00
5.00		0	99,753		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	263,213		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 12:04 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		44	1.00
2.00	Line 1 multiplied by 15 hours per week		660	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		780	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.55	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	102.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.79	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.40	34.40	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	7,051	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	7,051	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	7,051	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	68.79	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	45,401	22.00
23.00	Total salary equivalency (see instructions)	45,401	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	26,832	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	26,832	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	4,290	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	31,122	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	31,122	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 12:04 pm
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.79	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	45,401	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	31,122	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	76,523	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	26,832	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	4,290	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	31,122	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	4,290	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	4,290	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 12:04 pm

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					40	1.00
2.00	Line 1 multiplied by 15 hours per week					600	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	181.30	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.10	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.05	33.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					11,984	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					11,984	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					11,984	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					66.10	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					39,660	22.00
23.00	Total salary equivalency (see instructions)					39,660	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					8,593	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					8,593	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,430	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,023	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,023	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 12:04 pm

		Speech Pathology	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.10	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	39,660	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,023	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	49,683	63.00
64.00	Total cost of outside supplier services (from your records)	0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,593	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,430	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,023	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,430	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,430	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	223,005	223,005				1.00
1.01	FOUNDATION BLDG	53,162	0	53,162			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	409,092			409,092		2.00
4.00	EMPLOYEE BENEFITS	1,277,390	754	0	0	1,278,144	4.00
5.01	ADMITTING	111,800	819	0	0	23,171	5.01
5.02	A&G HOSPITAL ONLY	483,124	4,421	0	4,664	82,616	5.02
5.03	SHARED ADMIN & GENERAL	1,265,077	22,330	21,091	204,976	54,090	5.03
6.00	MAINTENANCE & REPAIRS	264,391	0	0	2,155	31,980	6.00
7.00	OPERATION OF PLANT	284,054	16,382	0	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	39,050	4,901	0	0	949	8.00
9.00	HOUSEKEEPING	103,355	2,088	0	1,776	17,195	9.00
10.00	DIETARY	194,382	13,300	0	729	36,054	10.00
11.00	CAFETERIA	0	6,890	0	0	0	11.00
13.00	NURSING ADMINISTRATION	105,231	1,117	0	0	22,841	13.00
14.00	CENTRAL SERVICES & SUPPLY	40,838	16,048	0	0	1,275	14.00
16.00	MEDICAL RECORDS & LIBRARY	158,780	7,580	0	5,149	18,256	16.00
17.00	SOCIAL SERVICE	55,751	544	0	0	12,122	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	940,003	41,798	0	17,472	192,319	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	133,855	15,528	0	70,459	14,788	50.00
53.00	ANESTHESIOLOGY	157	690	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	761,568	15,440	0	50,404	92,421	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	998,306	7,416	0	30,376	91,746	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	41,013	158	0	0	1,950	63.00
65.00	RESPIRATORY THERAPY	209,541	6,030	0	5,775	32,636	65.00
66.00	PHYSICAL THERAPY	306,965	5,457	0	3,778	63,468	66.00
67.00	OCCUPATIONAL THERAPY	39,856	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	9,060	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	21,796	292	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	325,424	2,983	0	1,773	41,729	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,533,103	0	22,915	6,060	229,550	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	57,635	2,217	0	0	40,323	90.00
91.00	EMERGENCY	1,102,129	11,329	0	3,546	98,360	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	388,446	4,843	0	0	68,432	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	85,141	281	0	0	9,873	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,022,480	211,636	44,006	409,092	1,278,144	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,076	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	9,156	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	9,293	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part I Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
202.00	TOTAL (sum lines 118-201)	12,022,480	223,005	53,162	409,092	1,278,144	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	ADMITTING	Subtotal	A&G HOSPITAL ONLY	Subtotal	SHARED ADMIN & GENERAL	
		5.01	5A.01	5.02	5A.02	5.03	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING	135,790					5.01
5.02	A&G HOSPITAL ONLY	0	574,825	574,825			5.02
5.03	SHARED ADMIN & GENERAL	0	1,567,564	78,855	1,646,419	1,646,419	5.03
6.00	MAINTENANCE & REPAIRS	0	298,526	15,017	313,543	49,840	6.00
7.00	OPERATION OF PLANT	0	300,436	15,113	315,549	50,159	7.00
8.00	LAUNDRY & LINEN SERVICE	0	44,900	2,259	47,159	7,496	8.00
9.00	HOUSEKEEPING	0	124,414	6,259	130,673	20,771	9.00
10.00	DIETARY	0	244,465	12,298	256,763	40,814	10.00
11.00	CAFETERIA	0	6,890	347	7,237	1,150	11.00
13.00	NURSING ADMINISTRATION	0	129,189	6,499	135,688	21,569	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	58,161	2,926	61,087	9,710	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	189,765	9,546	199,311	31,682	16.00
17.00	SOCIAL SERVICE	0	68,417	3,442	71,859	11,422	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,520	1,203,112	60,521	1,263,633	200,863	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,936	238,566	12,001	250,567	39,829	50.00
53.00	ANESTHESIOLOGY	1,424	2,271	114	2,385	379	53.00
54.00	RADIOLOGY-DIAGNOSTIC	29,081	948,914	47,734	996,648	158,424	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	32,032	1,159,876	58,346	1,218,222	193,645	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	681	43,802	2,203	46,005	7,313	63.00
65.00	RESPIRATORY THERAPY	5,412	259,394	13,049	272,443	43,307	65.00
66.00	PHYSICAL THERAPY	8,340	388,008	19,518	407,526	64,779	66.00
67.00	OCCUPATIONAL THERAPY	1,357	41,213	2,073	43,286	6,881	67.00
68.00	SPEECH PATHOLOGY	94	9,154	460	9,614	1,528	68.00
69.00	ELECTROCARDIOLOGY	2,611	24,699	1,242	25,941	4,124	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,391	385,300	19,382	404,682	64,327	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,791,628	90,121	1,881,749	299,121	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	3,834	104,009	5,232	109,241	17,365	90.00
91.00	EMERGENCY	22,077	1,237,441	62,248	1,299,689	206,595	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	461,721	23,226	484,947	77,086	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	95,295	4,794	100,089	15,910	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	135,790	12,001,955	574,825	12,001,955	1,646,089	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,076	0	2,076	330	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	9,156	0	9,156	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	9,293	0	9,293	0	194.03
200.00	Cross Foot Adjustments		0		0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	135,790	12,022,480	574,825	12,022,480	1,646,419	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS	363,383					6.00
7.00	OPERATION OF PLANT	26,605	392,313				7.00
8.00	LAUNDRY & LINEN SERVICE	7,960	10,784	73,399			8.00
9.00	HOUSEKEEPING	3,391	4,594	1,018	160,447		9.00
10.00	DIETARY	21,599	29,263	1,018	12,456	361,913	10.00
11.00	CAFETERIA	11,189	15,159	0	6,453	174,791	11.00
13.00	NURSING ADMINISTRATION	1,814	2,458	0	1,046	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	26,063	35,312	0	15,031	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	12,310	16,678	0	7,099	0	16.00
17.00	SOCIAL SERVICE	883	1,197	0	509	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	67,881	91,974	39,761	39,149	117,221	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	25,218	34,166	3,568	14,543	0	50.00
53.00	ANESTHESIOLOGY	1,121	1,518	0	646	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	25,075	33,973	2,549	14,461	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	12,044	16,317	1,018	6,946	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	256	347	0	148	0	63.00
65.00	RESPIRATORY THERAPY	9,793	13,268	1,018	5,647	0	65.00
66.00	PHYSICAL THERAPY	8,862	12,006	13,253	5,111	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	475	643	0	274	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,844	6,563	0	2,794	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	50,588	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	3,600	4,877	0	2,076	0	90.00
91.00	EMERGENCY	18,398	24,927	10,196	10,610	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	7,865	10,655	0	4,536	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	456	618	0	263	0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	348,290	367,297	73,399	149,798	292,012	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,568	0	1,945	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	69,901	194.02
194.03	KIDNEY CENTER	15,093	20,448	0	8,704	0	194.03
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)	363,383	392,313	73,399	160,447	361,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	215,979					11.00
13.00	NURSING ADMINISTRATION	2,919	165,494				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	147,203			14.00
16.00	MEDICAL RECORDS & LIBRARY	7,978	0	343	275,401		16.00
17.00	SOCIAL SERVICE	2,919	0	16	0	88,805	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	42,223	69,823	8,214	23,365	84,959	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,626	6,668	11,320	7,983	0	50.00
53.00	ANESTHESIOLOGY	0	0	39	2,887	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	22,571	0	9,035	58,983	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	29,121	0	14,333	64,960	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,381	0	63.00
65.00	RESPIRATORY THERAPY	9,015	6	7,117	10,976	0	65.00
66.00	PHYSICAL THERAPY	14,009	0	1,649	16,914	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	142	2,753	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	191	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	554	5,296	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,902	6,195	64,789	27,160	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	33,143	0	6,028	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	8,821	6,936	7,266	7,776	0	90.00
91.00	EMERGENCY	28,732	47,265	8,390	44,776	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	24,562	2,786	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	4,039	5,182	0	3,846	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	215,979	165,494	147,203	275,401	88,805	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	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	0	0	0	0	194.03
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)	215,979	165,494	147,203	275,401	88,805	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		19.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE						17.00
19.00	NONPHYSICIAN ANESTHETISTS	0					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	2,049,066	0	2,049,066		30.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	402,488	0	402,488		50.00
53.00	ANESTHESIOLOGY	0	8,975	0	8,975		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,321,719	0	1,321,719		54.00
57.00	CT SCAN	0	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	LABORATORY	0	1,556,606	0	1,556,606		60.00
60.01	BLOOD LABORATORY	0	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	55,450	0	55,450		63.00
65.00	RESPIRATORY THERAPY	0	372,590	0	372,590		65.00
66.00	PHYSICAL THERAPY	0	544,109	0	544,109		66.00
67.00	OCCUPATIONAL THERAPY	0	53,062	0	53,062		67.00
68.00	SPEECH PATHOLOGY	0	11,333	0	11,333		68.00
69.00	ELECTROCARDIOLOGY	0	37,307	0	37,307		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	587,256	0	587,256		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	2,270,629	0	2,270,629		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	0	167,958	0	167,958		90.00
91.00	EMERGENCY	0	1,699,578	0	1,699,578		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	CORF	0	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	612,437	0	612,437		101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0	0		113.00
116.00	HOSPICE	0	130,403	0	130,403		116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,880,966	0	11,880,966		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,919	0	8,919		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	BOARD OF HEALTH	0	9,156	0	9,156		194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	JAIL MEALS	0	69,901	0	69,901		194.02
194.03	KIDNEY CENTER	0	53,538	0	53,538		194.03
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	12,022,480	0	12,022,480		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	754	0	0	754	4.00
5.01	ADMITTING	0	819	0	0	819	5.01
5.02	A&G HOSPITAL ONLY	0	4,421	0	4,664	9,085	5.02
5.03	SHARED ADMIN & GENERAL	0	22,330	21,091	204,976	248,397	5.03
6.00	MAINTENANCE & REPAIRS	0	0	0	2,155	2,155	6.00
7.00	OPERATION OF PLANT	0	16,382	0	0	16,382	7.00
8.00	LAUNDRY & LINEN SERVICE	0	4,901	0	0	4,901	8.00
9.00	HOUSEKEEPING	0	2,088	0	1,776	3,864	9.00
10.00	DIETARY	0	13,300	0	729	14,029	10.00
11.00	CAFETERIA	0	6,890	0	0	6,890	11.00
13.00	NURSING ADMINISTRATION	0	1,117	0	0	1,117	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	16,048	0	0	16,048	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	7,580	0	5,149	12,729	16.00
17.00	SOCIAL SERVICE	0	544	0	0	544	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	41,798	0	17,472	59,270	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	15,528	0	70,459	85,987	50.00
53.00	ANESTHESIOLOGY	0	690	0	0	690	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	15,440	0	50,404	65,844	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	7,416	0	30,376	37,792	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	158	0	0	158	63.00
65.00	RESPIRATORY THERAPY	0	6,030	0	5,775	11,805	65.00
66.00	PHYSICAL THERAPY	0	5,457	0	3,778	9,235	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	292	0	0	292	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,983	0	1,773	4,756	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	22,915	6,060	28,975	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	2,217	0	0	2,217	90.00
91.00	EMERGENCY	0	11,329	0	3,546	14,875	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	4,843	0	0	4,843	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	281	0	0	281	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	211,636	44,006	409,092	664,734	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,076	0	0	2,076	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	9,156	0	9,156	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	9,293	0	0	9,293	194.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	223,005	53,162	409,092	685,259	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	EMPLOYEE BENEFITS	ADMITTING	A&G HOSPITAL ONLY	SHARED ADMIN & GENERAL	MAINTENANCE & REPAIRS	
		4.00	5.01	5.02	5.03	6.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	754					4.00
5.01	ADMITTING	14	833				5.01
5.02	A&G HOSPITAL ONLY	49	0	9,134			5.02
5.03	SHARED ADMIN & GENERAL	32	0	1,252	249,681		5.03
6.00	MAINTENANCE & REPAIRS	19	0	239	7,558	9,971	6.00
7.00	OPERATION OF PLANT	0	0	240	7,607	730	7.00
8.00	LAUNDRY & LINEN SERVICE	1	0	36	1,137	218	8.00
9.00	HOUSEKEEPING	10	0	99	3,150	93	9.00
10.00	DIETARY	21	0	195	6,190	593	10.00
11.00	CAFETERIA	0	0	6	174	307	11.00
13.00	NURSING ADMINISTRATION	13	0	103	3,271	50	13.00
14.00	CENTRAL SERVICES & SUPPLY	1	0	46	1,473	715	14.00
16.00	MEDICAL RECORDS & LIBRARY	11	0	152	4,805	338	16.00
17.00	SOCIAL SERVICE	7	0	55	1,732	24	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	114	71	961	30,461	1,862	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	9	24	191	6,040	692	50.00
53.00	ANESTHESIOLOGY	0	9	2	57	31	53.00
54.00	RADIOLOGY-DIAGNOSTIC	55	178	758	24,025	688	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	54	198	927	29,366	330	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1	4	35	1,109	7	63.00
65.00	RESPIRATORY THERAPY	19	33	207	6,568	269	65.00
66.00	PHYSICAL THERAPY	37	51	310	9,824	243	66.00
67.00	OCCUPATIONAL THERAPY	0	8	33	1,043	0	67.00
68.00	SPEECH PATHOLOGY	0	1	7	232	0	68.00
69.00	ELECTROCARDIOLOGY	0	16	20	625	13	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	25	82	308	9,755	133	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	134	0	1,435	45,363	1,388	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	24	23	83	2,633	99	90.00
91.00	EMERGENCY	58	135	989	31,330	505	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	40	0	369	11,690	216	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	6	0	76	2,413	13	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	754	833	9,134	249,631	9,557	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	50	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	0	0	0	414	194.03
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)	754	833	9,134	249,681	9,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	24,959					7.00
8.00	LAUNDRY & LINEN SERVICE	686	6,979				8.00
9.00	HOUSEKEEPING	292	97	7,605			9.00
10.00	DIETARY	1,862	97	590	23,577		10.00
11.00	CAFETERIA	964	0	306	11,387	20,034	11.00
13.00	NURSING ADMINISTRATION	156	0	50	0	271	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,247	0	712	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,061	0	336	0	740	16.00
17.00	SOCIAL SERVICE	76	0	24	0	271	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,851	3,781	1,858	7,636	3,917	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,174	339	689	0	800	50.00
53.00	ANESTHESIOLOGY	97	0	31	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,161	242	685	0	2,094	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,038	97	329	0	2,701	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	22	0	7	0	0	63.00
65.00	RESPIRATORY THERAPY	844	97	268	0	836	65.00
66.00	PHYSICAL THERAPY	764	1,260	242	0	1,300	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	41	0	13	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	418	0	132	0	547	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	3,074	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	310	0	98	0	818	90.00
91.00	EMERGENCY	1,586	969	503	0	2,665	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	678	0	215	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	39	0	12	0	0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,367	6,979	7,100	19,023	20,034	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	291	0	92	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	4,554	0	194.02
194.03	KIDNEY CENTER	1,301	0	413	0	0	194.03
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)	24,959	6,979	7,605	23,577	20,034	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	5,031					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	21,242				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	50	20,222			16.00
17.00	SOCIAL SERVICE	0	2	0	2,735		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,122	1,185	1,715	2,617		30.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	203	1,634	586	0		50.00
53.00	ANESTHESIOLOGY	0	6	212	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,304	4,330	0		54.00
57.00	CT SCAN	0	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	LABORATORY	0	2,068	4,773	0		60.00
60.01	BLOOD LABORATORY	0	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	101	0		63.00
65.00	RESPIRATORY THERAPY	0	1,027	806	0		65.00
66.00	PHYSICAL THERAPY	0	238	1,242	0		66.00
67.00	OCCUPATIONAL THERAPY	0	20	202	0		67.00
68.00	SPEECH PATHOLOGY	0	0	14	0		68.00
69.00	ELECTROCARDIOLOGY	0	80	389	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	188	9,349	1,994	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	870	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	211	1,048	571	0		90.00
91.00	EMERGENCY	1,437	1,211	3,287	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	CORF	0	0	0	0		99.10
101.00	HOME HEALTH AGENCY	747	402	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0	0		113.00
116.00	HOSPICE	123	748	0	118		116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,031	21,242	20,222	2,735	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	BOARD OF HEALTH	0	0	0	0		194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	JAIL MEALS	0	0	0	0		194.02
194.03	KIDNEY CENTER	0	0	0	0		194.03
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)	5,031	21,242	20,222	2,735	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	FOUNDATION BLDG					1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	ADMITTING					5.01
5.02	A&G HOSPITAL ONLY					5.02
5.03	SHARED ADMIN & GENERAL					5.03
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	123,421	0	123,421		30.00
41.00	SUBPROVIDER - IRF	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	99,368	0	99,368		50.00
53.00	ANESTHESIOLOGY	1,135	0	1,135		53.00
54.00	RADIOLOGY-DIAGNOSTIC	102,364	0	102,364		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	79,673	0	79,673		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1,444	0	1,444		63.00
65.00	RESPIRATORY THERAPY	22,779	0	22,779		65.00
66.00	PHYSICAL THERAPY	24,746	0	24,746		66.00
67.00	OCCUPATIONAL THERAPY	1,306	0	1,306		67.00
68.00	SPEECH PATHOLOGY	254	0	254		68.00
69.00	ELECTROCARDIOLOGY	1,489	0	1,489		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	27,687	0	27,687		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	81,239	0	81,239		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	8,135	0	8,135		90.00
91.00	EMERGENCY	59,550	0	59,550		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0		95.00
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	19,200	0	19,200		101.00
	SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	3,829	0	3,829		116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	657,619	0	657,619		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,509	0	2,509		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	BOARD OF HEALTH	9,156	0	9,156		194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0		194.01
194.02	JAIL MEALS	4,554	0	4,554		194.02
194.03	KIDNEY CENTER	11,421	0	11,421		194.03
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	685,259	0	685,259		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	
		1.00	1.01	2.00	4.00	5.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	38,130					1.00
1.01	FOUNDATION BLDG	0	12,356				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			308,646			2.00
4.00	EMPLOYEE BENEFITS	129	0	0	5,428,548		4.00
5.01	ADMITTING	140	0	0	98,411	16,304,670	5.01
5.02	A&G HOSPITAL ONLY	756	0	3,519	350,888	0	5.02
5.03	SHARED ADMIN & GENERAL	3,818	4,902	154,647	229,733	0	5.03
6.00	MAINTENANCE & REPAIRS	0	0	1,626	135,825	0	6.00
7.00	OPERATION OF PLANT	2,801	0	0	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	838	0	0	4,031	0	8.00
9.00	HOUSEKEEPING	357	0	1,340	73,029	0	9.00
10.00	DIETARY	2,274	0	550	153,130	0	10.00
11.00	CAFETERIA	1,178	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	191	0	0	97,009	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,744	0	0	5,415	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,296	0	3,885	77,535	0	16.00
17.00	SOCIAL SERVICE	93	0	0	51,486	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,147	0	13,182	816,819	1,383,303	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,655	0	53,159	62,809	472,638	50.00
53.00	ANESTHESIOLOGY	118	0	0	0	170,940	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,640	0	38,028	392,529	3,491,985	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,268	0	22,918	389,662	3,845,840	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	27	0	0	8,283	81,754	63.00
65.00	RESPIRATORY THERAPY	1,031	0	4,357	138,611	649,801	65.00
66.00	PHYSICAL THERAPY	933	0	2,850	269,562	1,001,389	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	162,989	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	11,291	68.00
69.00	ELECTROCARDIOLOGY	50	0	0	0	313,556	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	510	0	1,338	177,233	1,607,929	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	5,326	4,572	974,954	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	379	0	0	171,259	460,372	90.00
91.00	EMERGENCY	1,937	0	2,675	417,756	2,650,883	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	828	0	0	290,646	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	48	0	0	41,933	0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	36,186	10,228	308,646	5,428,548	16,304,670	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	2,128	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	1,589	0	0	0	0	194.03
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)	223,005	53,162	409,092	1,278,144	135,790	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	
		1.00	1.01	2.00	4.00	5.01	
203.00	Unit cost multiplier (Wkst. B, Part I)	5.848544	4.302525	1.325441	0.235449	0.008328	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				754	833	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000139	0.000051	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	Reconciliation	SHARED ADMIN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	6.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY	-574,825	11,427,130				5.02
5.03	SHARED ADMIN & GENERAL	0	1,567,564	-1,646,419	10,357,612		5.03
6.00	MAINTENANCE & REPAIRS	0	298,526	0	313,543	38,258	6.00
7.00	OPERATION OF PLANT	0	300,436	0	315,549	2,801	7.00
8.00	LAUNDRY & LINEN SERVICE	0	44,900	0	47,159	838	8.00
9.00	HOUSEKEEPING	0	124,414	0	130,673	357	9.00
10.00	DIETARY	0	244,465	0	256,763	2,274	10.00
11.00	CAFETERIA	0	6,890	0	7,237	1,178	11.00
13.00	NURSING ADMINISTRATION	0	129,189	0	135,688	191	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	58,161	0	61,087	2,744	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	189,765	0	199,311	1,296	16.00
17.00	SOCIAL SERVICE	0	68,417	0	71,859	93	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,203,112	0	1,263,633	7,147	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	238,566	0	250,567	2,655	50.00
53.00	ANESTHESIOLOGY	0	2,271	0	2,385	118	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	948,914	0	996,648	2,640	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,159,876	0	1,218,222	1,268	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	43,802	0	46,005	27	63.00
65.00	RESPIRATORY THERAPY	0	259,394	0	272,443	1,031	65.00
66.00	PHYSICAL THERAPY	0	388,008	0	407,526	933	66.00
67.00	OCCUPATIONAL THERAPY	0	41,213	0	43,286	0	67.00
68.00	SPEECH PATHOLOGY	0	9,154	0	9,614	0	68.00
69.00	ELECTROCARDIOLOGY	0	24,699	0	25,941	50	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	385,300	0	404,682	510	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,791,628	0	1,881,749	5,326	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	104,009	0	109,241	379	90.00
91.00	EMERGENCY	0	1,237,441	0	1,299,689	1,937	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	461,721	0	484,947	828	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	95,295	0	100,089	48	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-574,825	11,427,130	-1,646,419	10,355,536	36,669	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-2,076	0	0	2,076	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	-9,156	0	-9,156	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	-9,293	0	-9,293	0	1,589	194.03
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)		574,825		1,646,419	363,383	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.050304		0.158957	9.498223	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		9,134		249,681	9,971	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	Reconciliation	SHARED ADMIN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	6.00	
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000799		0.024106	0.260625	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	30,486					7.00
8.00	LAUNDRY & LINEN SERVICE	838	67,384				8.00
9.00	HOUSEKEEPING	357	935	29,291			9.00
10.00	DIETARY	2,274	935	2,274	18,608		10.00
11.00	CAFETERIA	1,178	0	1,178	8,987	6,660	11.00
13.00	NURSING ADMINISTRATION	191	0	191	0	90	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,744	0	2,744	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,296	0	1,296	0	246	16.00
17.00	SOCIAL SERVICE	93	0	93	0	90	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,147	36,501	7,147	6,027	1,302	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,655	3,276	2,655	0	266	50.00
53.00	ANESTHESIOLOGY	118	0	118	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,640	2,340	2,640	0	696	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,268	935	1,268	0	898	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	27	0	27	0	0	63.00
65.00	RESPIRATORY THERAPY	1,031	935	1,031	0	278	65.00
66.00	PHYSICAL THERAPY	933	12,167	933	0	432	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	50	0	50	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	510	0	510	0	182	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	1,022	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	379	0	379	0	272	90.00
91.00	EMERGENCY	1,937	9,360	1,937	0	886	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	828	0	828	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	48	0	48	0	0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,542	67,384	27,347	15,014	6,660	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	0	355	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	3,594	0	194.02
194.03	KIDNEY CENTER	1,589	0	1,589	0	0	194.03
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)	392,313	73,399	160,447	361,913	215,979	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.868628	1.089265	5.477689	19.449323	32.429279	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	24,959	6,979	7,605	23,577	20,034	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet B-1 Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.818704	0.103571	0.259636	1.267036	3.008108	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		13.00	14.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	FOUNDATION BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	A&G HOSPITAL ONLY						5.02
5.03	SHARED ADMIN & GENERAL						5.03
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	55,567					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	594,996				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,387	16,304,670			16.00
17.00	SOCIAL SERVICE	0	65	0	254		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	23,444	33,201	1,383,303	243		30.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,239	45,757	472,638	0	0	50.00
53.00	ANESTHESIOLOGY	0	157	170,940	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	36,518	3,491,985	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	57,936	3,845,840	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	81,754	0	0	63.00
65.00	RESPIRATORY THERAPY	2	28,766	649,801	0	0	65.00
66.00	PHYSICAL THERAPY	0	6,667	1,001,389	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	572	162,989	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	11,291	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	2,240	313,556	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,080	261,875	1,607,929	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	24,366	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,329	29,368	460,372	0	0	90.00
91.00	EMERGENCY	15,870	33,914	2,650,883	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	8,247	11,262	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	1,356	20,945	0	11	0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,567	594,996	16,304,670	254	0	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	0	0	192.00
194.00	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	JAIL MEALS	0	0	0	0	0	194.02
194.03	KIDNEY CENTER	0	0	0	0	0	194.03
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)	165,494	147,203	275,401	88,805	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.978278	0.247402	0.016891	349.625984	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 12:04 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		13.00	14.00	16.00	17.00	19.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	5,031	21,242	20,222	2,735	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.090539	0.035701	0.001240	10.767717	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,049,066		2,049,066	0	0	30.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	402,488		402,488	0	0	50.00
53.00	ANESTHESIOLOGY	8,975		8,975	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,321,719		1,321,719	0	0	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	1,556,606		1,556,606	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	55,450		55,450	0	0	63.00
65.00	RESPIRATORY THERAPY	372,590	0	372,590	0	0	65.00
66.00	PHYSICAL THERAPY	544,109	0	544,109	0	0	66.00
67.00	OCCUPATIONAL THERAPY	53,062	0	53,062	0	0	67.00
68.00	SPEECH PATHOLOGY	11,333	0	11,333	0	0	68.00
69.00	ELECTROCARDIOLOGY	37,307		37,307	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	587,256		587,256	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,270,629		2,270,629	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	167,958		167,958	0	0	90.00
91.00	EMERGENCY	1,699,578		1,699,578	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	442,085		442,085		0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0		0	0	0	95.00
99.10	CORF	0		0		0	99.10
101.00	HOME HEALTH AGENCY	612,437		612,437		0	101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0		0		0	109.00
110.00	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	ISLET ACQUISITION	0		0		0	111.00
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	130,403		130,403		0	116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00	Subtotal (see instructions)	12,323,051	0	12,323,051	0	0	200.00
201.00	Less Observation Beds	442,085		442,085		0	201.00
202.00	Total (see instructions)	11,880,966	0	11,880,966	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	1,119,985		1,119,985			30.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,941	468,698	472,639	0.851576	0.000000	50.00
53.00	ANESTHESIOLOGY	555	170,385	170,940	0.052504	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	120,734	3,371,251	3,491,985	0.378501	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	309,844	3,535,997	3,845,841	0.404750	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	27,456	54,298	81,754	0.678254	0.000000	63.00
65.00	RESPIRATORY THERAPY	260,375	389,426	649,801	0.573391	0.000000	65.00
66.00	PHYSICAL THERAPY	137,596	863,793	1,001,389	0.543354	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	80,551	82,438	162,989	0.325556	0.000000	67.00
68.00	SPEECH PATHOLOGY	3,632	7,660	11,292	1.003631	0.000000	68.00
69.00	ELECTROCARDIOLOGY	18,611	294,945	313,556	0.118980	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	827,062	780,868	1,607,930	0.365225	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	2,617,189	2,617,189			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	2,361	458,011	460,372	0.364831	0.000000	90.00
91.00	EMERGENCY	57,389	2,593,494	2,650,883	0.641137	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	24,855	238,464	263,319	1.678895	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	1,096,107	1,096,107			101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	4,272	59,410	63,682			116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00	Subtotal (see instructions)	2,999,219	17,082,434	20,081,653			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	2,999,219	17,082,434	20,081,653			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE			116.00
117.00	OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	99,368	472,639	0.210241	3,002	631	50.00
53.00	ANESTHESIOLOGY	1,135	170,940	0.006640	555	4	53.00
54.00	RADIOLOGY-DIAGNOSTIC	102,364	3,491,985	0.029314	66,577	1,952	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	79,673	3,845,841	0.020717	163,817	3,394	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1,444	81,754	0.017663	7,218	127	63.00
65.00	RESPIRATORY THERAPY	22,779	649,801	0.035055	148,265	5,197	65.00
66.00	PHYSICAL THERAPY	24,746	1,001,389	0.024712	13,699	339	66.00
67.00	OCCUPATIONAL THERAPY	1,306	162,989	0.008013	12,083	97	67.00
68.00	SPEECH PATHOLOGY	254	11,292	0.022494	919	21	68.00
69.00	ELECTROCARDIOLOGY	1,489	313,556	0.004749	7,666	36	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	27,687	1,607,930	0.017219	356,716	6,142	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	81,239	2,617,189	0.031041	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	8,135	460,372	0.017670	0	0	90.00
91.00	EMERGENCY	59,550	2,650,883	0.022464	2,883	65	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	263,319	0.000000	511	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	511,169	17,801,879		783,911	18,005	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	0	472,639	0.000000	0.000000	3,002	50.00
53.00	ANESTHESIOLOGY	0	170,940	0.000000	0.000000	555	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,491,985	0.000000	0.000000	66,577	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	3,845,841	0.000000	0.000000	163,817	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	81,754	0.000000	0.000000	7,218	63.00
65.00	RESPIRATORY THERAPY	0	649,801	0.000000	0.000000	148,265	65.00
66.00	PHYSICAL THERAPY	0	1,001,389	0.000000	0.000000	13,699	66.00
67.00	OCCUPATIONAL THERAPY	0	162,989	0.000000	0.000000	12,083	67.00
68.00	SPEECH PATHOLOGY	0	11,292	0.000000	0.000000	919	68.00
69.00	ELECTROCARDIOLOGY	0	313,556	0.000000	0.000000	7,666	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,607,930	0.000000	0.000000	356,716	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	2,617,189	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	460,372	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	2,650,883	0.000000	0.000000	2,883	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	263,319	0.000000	0.000000	511	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	17,801,879			783,911	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

	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)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	0.851576	0	161,852	0		50.00
53.00	ANESTHESIOLOGY	0.052504	0	60,214	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.378501	0	1,116,447	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.404750	0	1,437,846	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.678254	0	11,961	0		63.00
65.00	RESPIRATORY THERAPY	0.573391	0	138,370	0		65.00
66.00	PHYSICAL THERAPY	0.543354	0	373,664	0		66.00
67.00	OCCUPATIONAL THERAPY	0.325556	0	24,544	0		67.00
68.00	SPEECH PATHOLOGY	1.003631	0	4,332	0		68.00
69.00	ELECTROCARDIOLOGY	0.118980	0	147,446	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.365225	0	303,334	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.364831	0	222,227	0		90.00
91.00	EMERGENCY	0.641137	0	863,643	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.678895	0	127,005	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	4,992,885	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	4,992,885	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	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	0	137,829	0		50.00
53.00	ANESTHESIOLOGY	0	3,161	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	422,576	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	581,968	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	8,113	0		63.00
65.00	RESPIRATORY THERAPY	0	79,340	0		65.00
66.00	PHYSICAL THERAPY	0	203,032	0		66.00
67.00	OCCUPATIONAL THERAPY	0	7,990	0		67.00
68.00	SPEECH PATHOLOGY	0	4,348	0		68.00
69.00	ELECTROCARDIOLOGY	0	17,543	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	110,785	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	81,075	0		90.00
91.00	EMERGENCY	0	553,713	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	213,228	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	2,424,701	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,424,701	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	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	0.851576	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.052504	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.378501	0	0	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.404750	0	0	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.678254	0	0	0		63.00
65.00	RESPIRATORY THERAPY	0.573391	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.543354	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0.325556	0	0	0		67.00
68.00	SPEECH PATHOLOGY	1.003631	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.118980	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.365225	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.364831	0	0	0		90.00
91.00	EMERGENCY	0.641137	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.678895	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

	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)	1,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,080	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)	1,080	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	375	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)	416	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	498	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)	351	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)	392	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	116.26	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	122.07	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,049,066	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)	233	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)	1,465	25.00
26.00	Total swing-bed cost (see instructions)	867,258	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,181,808	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	671,724	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	671,724	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.759365	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)	621.97	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,181,808	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)	1,094.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	544,941	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)	544,941	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	330,198	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	875,139	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	384,085	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	428,950	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	813,035	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)	404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,094.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	442,085	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

	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: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		458,503		30.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.851576	3,002	2,556	50.00
53.00	ANESTHESIOLOGY	0.052504	555	29	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.378501	66,577	25,199	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.404750	163,817	66,305	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.678254	7,218	4,896	63.00
65.00	RESPIRATORY THERAPY	0.573391	148,265	85,014	65.00
66.00	PHYSICAL THERAPY	0.543354	13,699	7,443	66.00
67.00	OCCUPATIONAL THERAPY	0.325556	12,083	3,934	67.00
68.00	SPEECH PATHOLOGY	1.003631	919	922	68.00
69.00	ELECTROCARDIOLOGY	0.118980	7,666	912	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.365225	356,716	130,282	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.364831	0	0	90.00
91.00	EMERGENCY	0.641137	2,883	1,848	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.678895	511	858	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		783,911	330,198	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)		783,911		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		456,047		30.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.851576	939	800	50.00
53.00	ANESTHESIOLOGY	0.052504	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.378501	10,145	3,840	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.404750	71,080	28,770	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.678254	420	285	63.00
65.00	RESPIRATORY THERAPY	0.573391	80,581	46,204	65.00
66.00	PHYSICAL THERAPY	0.543354	115,897	62,973	66.00
67.00	OCCUPATIONAL THERAPY	0.325556	61,785	20,114	67.00
68.00	SPEECH PATHOLOGY	1.003631	2,436	2,445	68.00
69.00	ELECTROCARDIOLOGY	0.118980	7,871	936	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.365225	201,525	73,602	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.364831	0	0	90.00
91.00	EMERGENCY	0.641137	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.678895	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		552,679	239,969	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)		552,679		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,424,701	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,424,701	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,448,948	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)	24,207	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	699,067	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,725,674	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,725,674	30.00
31.00	Primary payer payments	875	31.00
32.00	Subtotal (line 30 minus line 31)	1,724,799	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)	86,209	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	86,209	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,209	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,811,008	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,811,008	40.00
41.00	Interim payments	1,747,635	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)	63,373	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		747,639		1,954,495	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/21/2011	50,166		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	05/20/2011	8,412	01/21/2011	42,941	3.50
3.51			0	05/20/2011	163,919	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)		41,754		-206,860	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)		789,393		1,747,635	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		63,373	6.01
6.02	SETTLEMENT TO PROGRAM		47,603		0	6.02
7.00	Total Medicare program liability (see instructions)		741,790		1,811,008	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: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/27/2012 12:04 pm

Component CCN: 14Z304 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,085,220		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/21/2011	42,600		0	3.01
3.02		05/20/2011	20,690		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		63,290		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)		1,148,510		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		96,734		0	6.02
7.00	Total Medicare program liability (see instructions)		1,051,776		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141304 Component CCN: 14Z304	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	821,165	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	242,369	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	743	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,063,534	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,063,534	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,063,534	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,758	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,051,776	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,051,776	0	19.00
20.00	Interim payments	1,148,510	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-96,734	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	875,139	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	875,139	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	883,890	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	883,890	19.00
20.00	Deductibles (exclude professional component)	144,300	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	739,590	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	739,590	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,200	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	2,200	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,200	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	741,790	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	741,790	30.00
31.00	Interim payments	789,393	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-47,603	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/27/2012 12:05 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	862,031	0	0	0	1.00
2.00	Temporary investments	239,349	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,940,836	0	0	0	4.00
5.00	Other receivable	64,083	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	209,640	0	0	0	7.00
8.00	Prepaid expenses	106,720	0	0	0	8.00
9.00	Other current assets	30,256	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)	3,452,915	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	43,583	0	0	0	12.00
13.00	Land improvements	24,966	0	0	0	13.00
14.00	Accumulated depreciation	-7,979	0	0	0	14.00
15.00	Buildings	3,832,441	0	0	0	15.00
16.00	Accumulated depreciation	-3,106,064	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	4,586,110	0	0	0	23.00
24.00	Accumulated depreciation	-3,937,515	0	0	0	24.00
25.00	Minor equipment depreciable	1,531,678	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)	2,967,220	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,540,573	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	51,664	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,592,237	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,012,372	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	92,558	0	0	0	37.00
38.00	Salaries, wages, and fees payable	744,049	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,787,522	0	0	0	40.00
41.00	Deferred income	28,396	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	382,933	0	0	0	43.00
44.00	Other current liabilities	65,867	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,101,325	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	215,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	290,098	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	505,098	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,606,423	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,405,949				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,405,949	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,012,372	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/27/2012 12:05 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		3,869,157		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		536,792				2.00
3.00	Total (sum of line 1 and line 2)		4,405,949		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,405,949		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,405,949		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/27/2012 12:05 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: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/27/2012 12:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	671,724		671,724	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	448,261		448,261	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,119,985		1,119,985	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,119,985		1,119,985	17.00
18.00	Ancillary services	1,790,316	10,019,797	11,810,113	18.00
19.00	Outpatient services	84,605	3,294,452	3,379,057	19.00
20.00	RURAL HEALTH CLINIC	0	2,617,189	2,617,189	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	1,096,107	1,096,107	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	63,681	0	63,681	26.00
27.00	PROFESSIONAL FEES	18,700	1,282,226	1,300,926	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,077,287	18,309,771	21,387,058	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,562,612		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	VENDOR REBATES	14,301			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)		14,301		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,548,311		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141304	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/27/2012 12:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	21,387,058	1.00
2.00	Less contractual allowances and discounts on patients' accounts	9,305,735	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,081,323	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,548,311	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-466,988	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	8,406	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	OTHER - TAX REVENUE	511,224	24.00
24.01	OTHER - OTHER REVENUE	457,267	24.01
24.02	OTHER - FARM INCOME	113,009	24.02
24.03	OTHER - GAIN ON SALE OF ASSETS	0	24.03
25.00	Total other income (sum of lines 6-24)	1,089,906	25.00
26.00	Total (line 5 plus line 25)	622,918	26.00
27.00	OTHER EXP-LOSS ON DISPOSAL OF ASSETS	86,126	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	86,126	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	536,792	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147462 | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	111,937	8,326	41,496	8,992	17,941	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	158,187	11,766	0	0	0	6.00
7.00	Physical Therapy	14,603	1,086	596	4,781	4	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	38,059	2,831	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	322,786	24,009	42,092	13,773	17,945	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147462 | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		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	188,692	-32,139	156,553	-20	156,533	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	169,953	0	169,953	0	169,953	6.00
7.00	Physical Therapy	21,070	0	21,070	0	21,070	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	40,890	0	40,890	0	40,890	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	420,605	-32,139	388,466	-20	388,446	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		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	156,533	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	169,953	0	0	0	0	6.00
7.00	Physical Therapy	21,070	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	40,890	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)	388,446	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141304 | HHA CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		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	156,533	156,533			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	169,953	114,713	284,666		6.00
7.00	Physical Therapy	21,070	14,221	35,291		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Home Health Aide	40,890	27,599	68,489		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	231,913		388,446		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part II Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		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	828				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	828		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	828	0	828	0	-156,533	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)	828	0	828	0	-156,533	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: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-1 Part II Date/Time Prepared: 1/27/2012 12:04 pm
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	231,913		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	169,953		6.00
7.00	Physical Therapy	21,070		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Home Health Aide	40,890		11.00
12.00	Supplies (see instructions)	0		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	231,913		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	156,533		25.00
26.00	Unit Cost Multiplier	0.674964		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 | Period: From 07/01/2010 | Worksheet H-2 Part I
HHA CCN: 147462 | To 06/30/2011 | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	0	4,843	0	0	18,788	1.00
2.00	Skilled Nursing Care	284,666	0	0	0	37,245	2.00
3.00	Physical Therapy	35,291	0	0	0	3,438	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	68,489	0	0	0	8,961	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	388,446	4,843	0	0	68,432	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.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I
HHA CCN: 147462 | Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I | PPS

		ADMITTING	Subtotal	A&G HOSPITAL ONLY	Subtotal	SHARED ADMIN & GENERAL	
		5.01	5A.01	5.02	5A.02	5.03	
1.00	Administrative and General	0	23,631	1,189	24,820	3,945	1.00
2.00	Skilled Nursing Care	0	321,911	16,193	338,104	53,744	2.00
3.00	Physical Therapy	0	38,729	1,948	40,677	6,466	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	77,450	3,896	81,346	12,931	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	461,721	23,226	484,947	77,086	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		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: 141304 HHA CCN: 147462

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

Worksheet H-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I

PPS

		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	7,865	10,655	0	4,536	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) (2)	7,865	10,655	0	4,536	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/27/2012 12:04 pm

HHA CCN: 147462 | Home Health Agency I | PPS

		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
1.00	Administrative and General	0	24,562	2,786	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	24,562	2,786	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/27/2012 12:04 pm

HHA CCN: 147462 | Home Health Agency I | PPS

		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	79,169	0	79,169		1.00
2.00	Skilled Nursing Care	0	391,848	0	391,848	58,174	2.00
3.00	Physical Therapy	0	47,143	0	47,143	6,999	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	94,277	0	94,277	13,996	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	612,437	0	612,437	79,169	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.					0.148460	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: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 1/27/2012 12:04 pm
		Home Health Agency I	PPS

		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	450,022		2.00
3.00	Physical Therapy	54,142		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	108,273		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) (2)	612,437		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.
H:\ACCT\REIMB\Mercer County Cost Reports\FYE 06302011\MCR Files\1413042011.mcrx

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part II | Date/Time Prepared: 1/27/2012 12:04 pm

HHA CCN: 147462 | Home Health Agency I | PPS

		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	
		1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	828	0	0	79,797	0	1.00
2.00	Skilled Nursing Care	0	0	0	158,187	0	2.00
3.00	Physical Therapy	0	0	0	14,603	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	38,059	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)	828	0	0	290,646	0	20.00
21.00	Total cost to be allocated	4,843	0	0	68,432	0	21.00
22.00	Unit cost multiplier	5.849034	0.000000	0.000000	0.235448	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part II Date/Time Prepared: 1/27/2012 12:04 pm
		Home Health Agency I	PPS

		Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	Reconciliation	SHARED ADMIN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	6.00	
1.00	Administrative and General	0	23,631	0	24,820	828	1.00
2.00	Skilled Nursing Care	0	321,911	0	338,104	0	2.00
3.00	Physical Therapy	0	38,729	0	40,677	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	77,450	0	81,346	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)		461,721		484,947	828	20.00
21.00	Total cost to be allocated		23,226		77,086	7,865	21.00
22.00	Unit cost multiplier		0.050303		0.158958	9.498792	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part II | Date/Time Prepared: 1/27/2012 12:04 pm

HHA CCN: 147462 | Home Health Agency I | PPS

		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	828	0	828	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	828	0	828	0	0	20.00
21.00	Total cost to be allocated	10,655	0	4,536	0	0	21.00
22.00	Unit cost multiplier	12.868357	0.000000	5.478261	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141304 HHA CCN: 147462

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

Worksheet H-2 Part II Date/Time Prepared: 1/27/2012 12:04 pm

Home Health Agency I

PPS

		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		13.00	14.00	16.00	17.00	19.00	
1.00	Administrative and General	8,247	11,262	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	8,247	11,262	0	0	0	20.00
21.00	Total cost to be allocated	24,562	2,786	0	0	0	21.00
22.00	Unit cost multiplier	2.978295	0.247381	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	450,022		450,022	2,558	1.00
2.00	Physical Therapy	3.00	54,142	0	54,142	394	2.00
3.00	Occupational Therapy	4.00	0	0	0	100	3.00
4.00	Speech Pathology	5.00	0	0	0	5	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	108,273		108,273	1,528	6.00
7.00	Total (sum of lines 1-6)		612,437	0	612,437	4,585	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		19340	0	0		8.00
9.00	Physical Therapy		19340	0	0		9.00
10.00	Occupational Therapy		19340	0	0		10.00
11.00	Speech Pathology		19340	0	0		11.00
12.00	Medical Social Services		19340	0	0		12.00
13.00	Home Health Aide		19340	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	0	0	0	9,885	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.543354	0	0	1.00
2.00	Occupational Therapy	67.00	0.325556	0	0	2.00
3.00	Speech Pathology	68.00	1.003631	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.000000	0	0	4.00
5.00	Cost of Drugs	73.00	0.365225	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 1/27/2012 12:04 pm

Title XVIII | Home Health Agency I | PPS

	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	175.93	667	1,081			1.00
2.00	Physical Therapy	137.42	206	95			2.00
3.00	Occupational Therapy	0.00	67	29			3.00
4.00	Speech Pathology	0.00	3	0			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	70.86	379	1,020			6.00
7.00	Total (sum of lines 1-6)		1,322	2,225			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

	Cost Center Description	Supplies and Drugs Cost Computations: 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		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	606	9,279	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	col. 2, line 3.00					2.00
3.00	Speech Pathology	col. 2, line 4.00					3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00					4.00
5.00	Cost of Drugs	col. 2, line 16.00					5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-3 Parts I-II Date/Time Prepared: 1/27/2012 12:04 pm
	Title XVIII	Home Health Agency I	PPS

	Cost Center Description	Cost of Services					
		Part A	Part B		Total Program Cost (sum of cols. 9-10)		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	117,345	190,180		307,525		1.00
2.00	Physical Therapy	28,309	13,055		41,364		2.00
3.00	Occupational Therapy	0	0		0		3.00
4.00	Speech Pathology	0	0		0		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	26,856	72,277		99,133		6.00
7.00	Total (sum of lines 1-6)	172,510	275,512		448,022		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	Subject to Deductibles & Coinsurance			
		9.00	10.00	11.00			
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0	0	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 1/27/2012 12:04 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	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	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)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	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	155,595	201,262	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	2,110	11,702	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,340	5,878	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,134	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	48	4,786	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)	161,227	223,628	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	161,227	223,628	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	161,227	223,628	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)	161,227	223,628	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	161,227	223,628	31.00
32.00	Interim payments (see instructions)	161,227	223,628	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: 141304 HHA CCN: 147462	Period: From 07/01/2010 To 06/30/2011	Worksheet H-5 Date/Time Prepared: 1/27/2012 12:04 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		161,227		223,628	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)		161,227		223,628	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)		161,227		223,628	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: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K

Hospice CCN: 141593 | Date/Time Prepared: 1/27/2012 12:05 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	1,600	122	0	0	0	9.00
10.00	Nursing Care	40,333	3,064	6,490	236	971	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	11,379	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	20,946	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)	41,933	3,186	6,490	236	33,296	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K | Date/Time Prepared: 1/27/2012 12:05 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	1,722	0	1,722	0	1,722	9.00
10.00	Nursing Care	51,094	0	51,094	0	51,094	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	11,379	0	11,379	0	11,379	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	20,946	0	20,946	0	20,946	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)	85,141	0	85,141	0	85,141	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141304 Hospice CCN: 141593

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

Worksheet K-1

Date/Time Prepared: 1/27/2012 12:05 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	1,829	1,580	33,319	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	1,829	1,580	33,319	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141304 Hospice CCN: 141593

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

Worksheet K-1

Date/Time Prepared: 1/27/2012 12:05 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	1,600	1,600		9.00
10.00	Nursing Care		3,605	0	40,333		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	3,605	1,600	41,933		39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 141304 Hospice CCN: 141593

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

Worksheet K-2

Date/Time Prepared: 1/27/2012 12:05 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	139	120	2,531	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	139	120	2,531	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) | Provider CCN: 141304 | Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-2 | Date/Time Prepared: 1/27/2012 12:05 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	122	122		9.00
10.00	Nursing Care		274	0	3,064		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	274	122	3,186		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-3 Date/Time Prepared: 1/27/2012 12:05 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	236	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	236	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 141304 | Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-3 | Date/Time Prepared: 1/27/2012 12:05 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	0	236		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	0	236		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part I Date/Time Prepared: 1/27/2012 12:05 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	1,722	0	0	0	0	9.00
10.00	Nursing Care	51,094	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	11,379	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	20,946	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)	85,141	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part I Date/Time Prepared: 1/27/2012 12:05 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	1,722	0	1,722		9.00
10.00	Nursing Care	0	51,094	0	51,094		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	11,379	0	11,379		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	20,946	0	20,946		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	85,141	0	85,141		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part II Date/Time Prepared: 1/27/2012 12:05 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: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part II Date/Time Prepared: 1/27/2012 12:05 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	85,141		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	1,722		9.00
10.00	Nursing Care	0	51,094		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	11,379		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	20,946		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: 141304 | Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I | Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		281	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	1,722	0	0	0	377	4.00
5.00	Nursing Care	51,094	0	0	0	9,496	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	11,379	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	20,946	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)	85,141	281	0	0	9,873	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

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

Worksheet K-5 Part I Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	ADMITTING	Subtotal	A&G HOSPITAL ONLY	Subtotal	SHARED ADMIN & GENERAL	
		5.01	5A.01	5.02	5A.02	5.03	
1.00	Administrative and General	0	281	14	295	47	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	2,099	106	2,205	351	4.00
5.00	Nursing Care	0	60,590	3,048	63,638	10,115	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	11,379	572	11,951	1,900	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	20,946	1,054	22,000	3,497	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	95,295	4,794	100,089	15,910	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000		0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I

Hospice CCN: 141593 | Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	456	618	0	263	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)	456	618	0	263	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304
Hospice CCN: 141593

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

Worksheet K-5
Part I
Date/Time Prepared:
1/27/2012 12:05 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
1.00	Administrative and General	0	4,039	5,182	0	3,846	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	4,039	5,182	0	3,846	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

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

Worksheet K-5 Part I Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	
		19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	14,746				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	2,556	0	2,556	326	4.00
5.00	Nursing Care	0	73,753	0	73,753	9,403	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	13,851	0	13,851	1,766	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	25,497	0	25,497	3,251	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	130,403	0	130,403		34.00
35.00	Unit Cost Multiplier (see instructions)					0.127498	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	Total Hospice Costs (cols. 26 ± 27)		
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	2,882		4.00
5.00	Nursing Care	83,156		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	15,617		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	28,748		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)	130,403		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

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

Worksheet K-5
Part II
Date/Time Prepared:
1/27/2012 12:05 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	
		1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	48	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	1,600	0	4.00
5.00	Nursing Care	0	0	0	40,333	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)	48	0	0	41,933	0	34.00
35.00	Total cost to be allocated	281	0	0	9,873	0	35.00
36.00	Unit Cost Multiplier (see instructions)	5.854167	0.000000	0.000000	0.235447	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304 | Hospice CCN: 141593 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part II | Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

	Cost Center Description	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	Reconciliation	SHARED ADMIN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	6.00	
1.00	Administrative and General	0	281	0	295	48	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	2,099	0	2,205	0	4.00
5.00	Nursing Care	0	60,590	0	63,638	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	11,379	0	11,951	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	20,946	0	22,000	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)		95,295		100,089	48	34.00
35.00	Total cost to be allocated		4,794		15,910	456	35.00
36.00	Unit Cost Multiplier (see instructions)		0.050307		0.158959	9.500000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

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

Worksheet K-5
Part II
Date/Time Prepared:
1/27/2012 12:05 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	48	0	48	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	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)	48	0	48	0	0	34.00
35.00	Total cost to be allocated	618	0	263	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	12.875000	0.000000	5.479167	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

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

Worksheet K-5
Part II
Date/Time Prepared:
1/27/2012 12:05 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		13.00	14.00	16.00	17.00	19.00	
1.00	Administrative and General	1,356	20,945	0	11	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)	1,356	20,945	0	11	0	34.00
35.00	Total cost to be allocated	4,039	5,182	0	3,846	0	35.00
36.00	Unit Cost Multiplier (see instructions)	2.978614	0.247410	0.000000	349.636364	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 141304 | Period: From 07/01/2010 | Worksheet K-5 Part III
Hospice CCN: 141593 | To 06/30/2011 | Date/Time Prepared: 1/27/2012 12:05 pm

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	0.543354	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.325556	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.003631	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.365225	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.404750	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	0.000000	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST	Provider CCN: 141304 Hospice CCN: 141593	Period: From 07/01/2010 To 06/30/2011	Worksheet K-6 Date/Time Prepared: 1/27/2012 12:05 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				130,403	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				2,018	2.00
3.00	Average cost per diem (line 1 divided by line 2)				64.62	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,963				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	126,849				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			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)			55		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			3,554		13.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/27/2012 12:05 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	441,261	304,278	745,539	0	745,539	1.00
2.00	Physician Assistant	231,224	14,807	246,031	0	246,031	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	211,310	13,532	224,842	0	224,842	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	23,781	1,523	25,304	0	25,304	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	907,576	334,140	1,241,716	0	1,241,716	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	190,158	190,158	0	190,158	13.00
14.00	Subtotal (sum of lines 11-13)	0	190,158	190,158	0	190,158	14.00
15.00	Medical Supplies	0	20,665	20,665	0	20,665	15.00
16.00	Transportation (Health Care Staff)	0	8,656	8,656	0	8,656	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	3,523	3,523	0	3,523	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	32,844	32,844	0	32,844	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	907,576	557,142	1,464,718	0	1,464,718	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	83,257	83,257	-65,490	17,767	29.00
30.00	Administrative Costs	140,575	60,200	200,775	-73,198	127,577	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	140,575	143,457	284,032	-138,688	145,344	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,048,151	700,599	1,748,750	-138,688	1,610,062	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/27/2012 12:05 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	-45,148	700,391		1.00
2.00	Physician Assistant	0	246,031		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	224,842		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	25,304		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	-45,148	1,196,568		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	190,158		13.00
14.00	Subtotal (sum of lines 11-13)	0	190,158		14.00
15.00	Medical Supplies	0	20,665		15.00
16.00	Transportation (Health Care Staff)	0	8,656		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	3,523		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	32,844		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-45,148	1,419,570		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	-28,606	-10,839		29.00
30.00	Administrative Costs	-3,205	124,372		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-31,811	113,533		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-76,959	1,533,103		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2 Date/Time Prepared: 1/27/2012 12:05 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	2.74	11,330	4,200	11,508		1.00
2.00	Physician Assistant	0.90	3,988	2,100	1,890		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	3.64	15,318		13,398	15,318	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.64	15,318			15,318	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,419,570	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)					1,419,570	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)					113,533	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					737,526	15.00
16.00	Total overhead (sum of lines 14 and 15)					851,059	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					851,059	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					851,059	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,270,629	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/27/2012 12:05 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)		2,270,629	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,270,629	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		15,318	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)		15,318	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		148.23	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)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	148.23	148.23	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,980	1,981	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	293,495	293,644	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) *	293,495	293,644	16.00
16.01	Total program charges (see instructions)(from contractor's records)		655,113	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%)		188,146	16.04
16.05	Total program cost (see instructions)	234,796	188,146	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		58,461	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		119,259	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		422,942	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		422,942	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)		422,942	26.00
27.00	Interim payments		444,068	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)		-21,126	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/27/2012 12:05 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		399,674	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		01/21/2011	44,394	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)		44,394	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		444,068	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,126	6.02
7.00	Total Medicare program liability (see instructions)		422,942	7.00

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