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: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/16/2012 11:00 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/16/2012 Time: 11:00 am
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 FAIRFIELD MEMORIAL 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	338,755	-431,027	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	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		78,501		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	338,755	-352,526	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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 NW 11TH STREET	PO Box:			1.00
2.00	City: FAIRFIELD	State: IL	Zip Code: 62837	County: WAYNE	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	FAIRFIELD MEMORIAL HOSPITAL	141311	14999	1	04/01/2001	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	FAIRFIELD MEMORIAL HOSPITAL	145552	14999		03/26/1985	N	P	N	7.00
8.00	Swing Beds - NF	FAIRFIELD MEMORIAL HOSPITAL WAYFAIR	140000	14999		07/01/1966	N		O	8.00
9.00	Hospital-Based SNF						N	N	N	9.00
10.00	Hospital-Based NF						N		N	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	14999		05/01/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	14999		03/13/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? 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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF then enter the in-state Mediciad paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	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:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 10:35 am

		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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 10:35 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

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

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

		1.00	2.00	
	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.	0		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.	0	0	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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 10:35 am

		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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/16/2012 10:35 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		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)		Y	10/12/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/16/2012 10:35 am

		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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.				N	35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/16/2012 10:35 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/12/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 1/16/2012 10:35 am

	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	21	7,665	60,528.00		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)		21	7,665	60,528.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	6,072.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		25	9,125	66,600.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	30	10,950			19.00
20.00	NURSING FACILITY	45.00	104	37,960			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						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		159				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,864	286	2,522		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,864	286	2,522		7.00
8.00	INTENSIVE CARE UNIT	0	201	0	253		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0		0	0		13.00
14.00	Total (see instructions)	0	2,065	286	2,775		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	2,243	0	6,669		19.00
20.00	NURSING FACILITY	0		0	18,358		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	3,133	0	3,891		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	5,812	0	17,621		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	774		28.00
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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	542	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	162.21	0.00	0	542	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	17.64	0.00			19.00
20.00	NURSING FACILITY	0.00	48.91	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	5.46	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00	4.62	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	238.84	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	81	776		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)	81	776		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 1/16/2012 10:35 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	114,835	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,152,453	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	46,659	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	166,666	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	651,493	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,736	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,154,842	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141311 | Component CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-4 | Date/Time Prepared: 1/16/2012 10:35 am

Home Health Agency I | PPS

		1.00	
0.00	County	WAYNE	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	168.00	0.00	43.00	211.00	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)	0.00	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		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	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		0.00	0.00	0.00	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).		14999			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	2,060	37	56	8	2,161	21.00
22.00	Skilled Nursing Visit Charges	226,600	4,070	6,160	880	237,710	22.00
23.00	Physical Therapy Visits	782	0	9	7	798	23.00
24.00	Physical Therapy Visit Charges	86,020	0	990	770	87,780	24.00
25.00	Occupational Therapy Visits	123	0	1	0	124	25.00
26.00	Occupational Therapy Visit Charges	13,503	0	110	0	13,613	26.00
27.00	Speech Pathology Visits	49	0	0	0	49	27.00
28.00	Speech Pathology Visit Charges	5,635	0	0	0	5,635	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	0	0	0	1	31.00
32.00	Home Health Aide Visit Charges	62	0	0	0	62	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,015	37	66	15	3,133	33.00
34.00	Other Charges	35,840	189	863	0	36,892	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	367,660	4,259	8,123	1,650	381,692	35.00
36.00	Total Number of Episodes (standard/non outlier)	200		24	2	226	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	24,537	0	602	63	25,202	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 1/16/2012 10:35 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	30	0	30	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	49	0	49	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	42	0	42	8.00
9.00		RMX	10	0	10	9.00
10.00		RML	37	0	37	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	23	0	23	12.00
13.00		RUB	94	0	94	13.00
14.00		RUA	111	0	111	14.00
15.00		RVC	121	0	121	15.00
16.00		RVB	293	0	293	16.00
17.00		RVA	423	0	423	17.00
18.00		RHC	148	0	148	18.00
19.00		RHB	238	0	238	19.00
20.00		RHA	237	0	237	20.00
21.00		RMC	14	0	14	21.00
22.00		RMB	53	0	53	22.00
23.00		RMA	95	0	95	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	41	0	41	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	2	0	2	33.00
34.00		HC1	5	0	5	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	10	0	10	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	10	0	10	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	6	0	6	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	39	0	39	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	39	0	39	52.00
53.00		CA2	12	0	12	53.00
54.00		CA1	30	0	30	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	20	0	20	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/16/2012 10:35 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	5	0	5	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,243	0	2,243	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	14999	14999	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	815,084			207.00

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

Provider CCN: 141311 Component CCN: 148500

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

Worksheet S-8

Date/Time Prepared: 1/16/2012 10:35 am

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	303 NW 11TH STREET		1.00
	City	State	Zip Code	
	1.00	2.00	3.00	
2.00	City, State, Zip Code, County — FAIRFIELD	IL	62837	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
		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			09:00	05:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	FAIRFIELD RHC	148500	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)	N	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 10:35 am
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	WAYNE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	05:00	09:00	05:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 10:35 am
		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	09:00	05:00	09:00	05:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 10:35 am
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/16/2012 10:35 am

		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)	0.453044	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,673,263	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,845,890	6.00
7.00	Medicaid cost (line 1 times line 6)	4,007,577	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)	1,334,314	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)	1,521,817	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,334,314	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	1,143,632	94,951	1,238,583	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	518,116	43,017	561,133	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)	518,116	43,017	561,133	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	661,816	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	661,816	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	0	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	0	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	561,133	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,895,447	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/16/2012 10:35 am

	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	CAP REL COSTS-BLDG & FIXT		911,151	911,151	0	911,151	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	0	252,421	252,421	2.00
4.00	EMPLOYEE BENEFITS	89,489	2,181,493	2,270,982	0	2,270,982	4.00
5.00	ADMINISTRATIVE & GENERAL	892,575	1,788,732	2,681,307	155,413	2,836,720	5.00
6.00	MAINTENANCE & REPAIRS	235,016	264,983	499,999	-585	499,414	6.00
7.00	OPERATION OF PLANT	0	443,249	443,249	0	443,249	7.00
8.00	LAUNDRY & LINEN SERVICE	0	267,895	267,895	0	267,895	8.00
9.00	HOUSEKEEPING	268,363	130,738	399,101	0	399,101	9.00
10.00	DIETARY	137,805	439,863	577,668	-223,319	354,349	10.00
11.00	CAFETERIA	0	0	0	222,077	222,077	11.00
13.00	NURSING ADMINISTRATION	197,049	18,083	215,132	0	215,132	13.00
16.00	MEDICAL RECORDS & LIBRARY	252,459	85,492	337,951	-383	337,568	16.00
17.00	SOCIAL SERVICE	67,764	7,103	74,867	0	74,867	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,064,639	63,867	1,128,506	-687	1,127,819	30.00
31.00	INTENSIVE CARE UNIT	210,856	7,635	218,491	0	218,491	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	569,386	52,679	622,065	-1,935	620,130	44.00
45.00	NURSING FACILITY	1,353,957	1,277,649	2,631,606	0	2,631,606	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	957,230	240,564	1,197,794	-25,949	1,171,845	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	399,600	1,094,101	1,493,701	-118,600	1,375,101	54.00
60.00	LABORATORY	747,210	1,082,224	1,829,434	-73,580	1,755,854	60.00
65.00	RESPIRATORY THERAPY	143,886	124,428	268,314	-82,742	185,572	65.00
66.00	PHYSICAL THERAPY	644,138	17,443	661,581	0	661,581	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	67,881	67,881	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,166	751,901	796,067	-54,556	741,511	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	54,556	54,556	72.00
73.00	DRUGS CHARGED TO PATIENTS	213,366	818,809	1,032,175	0	1,032,175	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,534,316	389,013	1,923,329	-5,683	1,917,646	88.00
90.00	CLINIC	195,064	133,513	328,577	0	328,577	90.00
91.00	EMERGENCY	572,779	1,378,936	1,951,715	-1,885	1,949,830	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	263,951	60,818	324,769	0	324,769	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		178,798	178,798	-162,444	16,354	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,055,064	14,211,160	25,266,224	0	25,266,224	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	11,055,064	14,211,160	25,266,224	0	25,266,224	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-102,742	808,409		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-56	252,365		2.00
4.00	EMPLOYEE BENEFITS	0	2,270,982		4.00
5.00	ADMINISTRATIVE & GENERAL	-169,740	2,666,980		5.00
6.00	MAINTENANCE & REPAIRS	0	499,414		6.00
7.00	OPERATION OF PLANT	0	443,249		7.00
8.00	LAUNDRY & LINEN SERVICE	0	267,895		8.00
9.00	HOUSEKEEPING	0	399,101		9.00
10.00	DIETARY	0	354,349		10.00
11.00	CAFETERIA	-132,912	89,165		11.00
13.00	NURSING ADMINISTRATION	0	215,132		13.00
16.00	MEDICAL RECORDS & LIBRARY	-8,998	328,570		16.00
17.00	SOCIAL SERVICE	0	74,867		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,127,819		30.00
31.00	INTENSIVE CARE UNIT	0	218,491		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	620,130		44.00
45.00	NURSING FACILITY	0	2,631,606		45.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-462,632	709,213		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	700	1,375,801		54.00
60.00	LABORATORY	0	1,755,854		60.00
65.00	RESPIRATORY THERAPY	0	185,572		65.00
66.00	PHYSICAL THERAPY	0	661,581		66.00
69.00	ELECTROCARDIOLOGY	-34,869	33,012		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	741,511		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	54,556		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,032,175		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	1,917,646		88.00
90.00	CLINIC	0	328,577		90.00
91.00	EMERGENCY	-868,031	1,081,799		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	324,769		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	-16,354	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,795,634	23,470,590		118.00
	NONREIMBURSABLE COST CENTERS				
194.00	DR. OFFICE	0	0		194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,795,634	23,470,590		200.00

RECLASSIFICATIONS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/16/2012 10:35 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	52,977	169,100	1.00
	TOTALS		52,977	169,100	
	C - EKG				
1.00	ELECTROCARDIOLOGY	69.00	33,012	34,869	1.00
	TOTALS		33,012	34,869	
	D - RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	252,421	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	252,421	
	E - INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	162,444	1.00
	TOTALS		0	162,444	
	F - IMPLANTABLE DEVICE				
1.00	IMP. DEV CHARGED TO PATIENT	72.00	0	54,556	1.00
	TOTALS		0	54,556	
500.00	Grand Total: Increases		85,989	673,390	500.00

RECLASSIFICATIONS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/16/2012 10:35 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	52,977	169,100	0		1.00
	TOTALS		52,977	169,100			
	C - EKG						
1.00	RESPIRATORY THERAPY	65.00	33,012	34,869	0		1.00
	TOTALS		33,012	34,869			
	D - RENTAL						
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,031	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	585	0		3.00
6.00	DIETARY	10.00	0	1,242	0		6.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	383	0		8.00
10.00	ADULTS & PEDIATRICS	30.00	0	687	0		10.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,935	0		12.00
13.00	OPERATING ROOM	50.00	0	25,949	0		13.00
14.00	RADIOLOGY - DIAGNOSTIC	54.00	0	118,600	0		14.00
15.00	LABORATORY	60.00	0	73,580	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	14,861	0		16.00
21.00	EMERGENCY	91.00	0	1,885	0		21.00
22.00	RURAL HEALTH CLINIC	88.00	0	5,683	0		22.00
	TOTALS		0	252,421			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	162,444	0		1.00
	TOTALS		0	162,444			
	F - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	54,556	0		1.00
	TOTALS		0	54,556			
500.00	Grand Total: Decreases		85,989	673,390			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 10:35 am

			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	312,785	78,084	0	78,084	0	1.00
2.00	Land Improvements	474,937	165,491	0	165,491	0	2.00
3.00	Buildings and Fixtures	16,664,407	5,962,190	0	5,962,190	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	741,400	0	0	0	0	5.00
6.00	Movable Equipment	8,279,805	347,175	0	347,175	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,473,334	6,552,940	0	6,552,940	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,473,334	6,552,940	0	6,552,940	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	CAP REL COSTS-BLDG & FIXT	911,151	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	911,151	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 10:35 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	390,869	0				1.00
2.00	Land Improvements	640,428	0				2.00
3.00	Buildings and Fixtures	22,626,597	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	741,400	0				5.00
6.00	Movable Equipment	8,626,980	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	33,026,274	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	33,026,274	0				10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	911,151				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	911,151				3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	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	CAP REL COSTS-BLDG & FIXT	0	0	0	808,409	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	252,365	2.00
3.00	Total (sum of lines 1-2)	0	0	0	808,409	252,365	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 10:35 am

	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	808,409	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	252,365	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,060,774	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/16/2012 10:35 am

				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	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-16,354	INTEREST EXPENSE	113.00	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)	A	-4,765	ADMINISTRATIVE & GENERAL	5.00	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	-1,365,532			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	700			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-132,912	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-8,998	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	OFFICE SPACE RENTAL	B	-67,047	CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01	RINARD & WEBER CLINIC	A	-35,695	CAP REL COSTS-BLDG & FIXT	1.00	33.01
33.02	RECRUITING	A	-24,482	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	ADVERTISING	A	-104,841	ADMINISTRATIVE & GENERAL	5.00	33.03
33.04	OTHER REVENUE	B	-35,652	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	LIFELINE	B	-56	CAP REL COSTS-MVBLE EQUIP	2.00	33.05
33.06			0		0.00	33.06
33.07			0		0.00	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,795,634			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/16/2012 10:35 am

		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	OFFICE SPACE RENTAL	9		33.00
33.01	RINARD & WEBER CLINIC	9		33.01
33.02	RECRUITING	0		33.02
33.03	ADVERTISING	0		33.03
33.04	OTHER REVENUE	0		33.04
33.05	LIFELINE	10		33.05
33.06		0		33.06
33.07		0		33.07
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: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/16/2012 10:35 am

		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		54.00	RADIOLOGY - DIAGNOSTIC	MRI	1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
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		G	DSSI	15.00		6.00
7.00				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:		OTHER			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: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/16/2012 10:35 am

		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		244,731	244,031	700	0		1.00
2.00		0	0	0	0		2.00
3.00		0	0	0	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	244,731	244,031	700			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:				

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			0.00		6.00
7.00			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 10:35 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		50.00	ANESTHESIA	462,632	462,632	1.00
2.00		60.00	LAB	25,500	0	2.00
3.00		69.00	EKG/EEG	34,869	34,869	3.00
4.00		91.00	ER	1,285,020	868,031	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,808,021	1,365,532	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 10:35 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		25,500	0	192	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		416,989	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		442,489		192	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 10:35 am

		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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 10:35 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	462,632		1.00
2.00		0	0		2.00
3.00		0	34,869		3.00
4.00		0	868,031		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	1,365,532		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	808,409	808,409				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	252,365		252,365			2.00
4.00	EMPLOYEE BENEFITS	2,270,982	0	0	2,270,982		4.00
5.00	ADMINISTRATIVE & GENERAL	2,666,980	94,598	29,531	210,893	3,002,002	5.00
6.00	MAINTENANCE & REPAIRS	499,414	29,927	9,342	55,528	594,211	6.00
7.00	OPERATION OF PLANT	443,249	19,560	6,106	0	468,915	7.00
8.00	LAUNDRY & LINEN SERVICE	267,895	13,516	4,219	0	285,630	8.00
9.00	HOUSEKEEPING	399,101	1,870	584	63,407	464,962	9.00
10.00	DIETARY	354,349	4,914	1,534	20,043	380,840	10.00
11.00	CAFETERIA	89,165	5,231	1,633	12,517	108,546	11.00
13.00	NURSING ADMINISTRATION	215,132	1,353	422	46,558	263,465	13.00
16.00	MEDICAL RECORDS & LIBRARY	328,570	11,687	3,649	59,650	403,556	16.00
17.00	SOCIAL SERVICE	74,867	1,691	528	16,011	93,097	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,127,819	154,272	48,161	251,548	1,581,800	30.00
31.00	INTENSIVE CARE UNIT	218,491	14,086	4,397	49,820	286,794	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	620,130	90,382	28,215	134,532	873,259	44.00
45.00	NURSING FACILITY	2,631,606	0	0	0	2,631,606	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	709,213	68,603	21,416	226,170	1,025,402	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	1,375,801	48,377	15,102	94,415	1,533,695	54.00
60.00	LABORATORY	1,755,854	23,967	7,482	176,547	1,963,850	60.00
65.00	RESPIRATORY THERAPY	185,572	17,795	5,555	26,197	235,119	65.00
66.00	PHYSICAL THERAPY	661,581	38,137	11,906	152,194	863,818	66.00
69.00	ELECTROCARDIOLOGY	33,012	0	0	7,800	40,812	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	741,511	18,768	5,859	10,435	776,573	71.00
72.00	IMP. DEV CHARGED TO PATIENT	54,556	0	0	0	54,556	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,032,175	28,828	8,999	50,413	1,120,415	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,917,646	57,687	18,008	362,517	2,355,858	88.00
90.00	CLINIC	328,577	18,334	5,723	46,089	398,723	90.00
91.00	EMERGENCY	1,081,799	24,537	7,660	135,333	1,249,329	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	324,769	20,289	6,334	62,365	413,757	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,470,590	808,409	252,365	2,270,982	23,470,590	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	23,470,590	808,409	252,365	2,270,982	23,470,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,002,002					5.00
6.00	MAINTENANCE & REPAIRS	100,007	694,218				6.00
7.00	OPERATION OF PLANT	78,919	19,856	567,690			7.00
8.00	LAUNDRY & LINEN SERVICE	48,072	13,720	11,550	358,972		8.00
9.00	HOUSEKEEPING	78,254	1,899	1,598	9,718	556,431	9.00
10.00	DIETARY	64,096	4,988	4,199	5,400	4,213	10.00
11.00	CAFETERIA	18,269	5,310	4,470	5,235	4,485	11.00
13.00	NURSING ADMINISTRATION	44,342	1,373	1,156	0	1,160	13.00
16.00	MEDICAL RECORDS & LIBRARY	67,919	11,864	9,987	0	10,021	16.00
17.00	SOCIAL SERVICE	15,668	1,716	1,445	0	1,450	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	266,220	156,602	131,831	121,542	132,281	30.00
31.00	INTENSIVE CARE UNIT	48,268	14,299	12,037	8,235	12,078	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	146,971	91,748	77,235	152,282	77,498	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	172,577	69,640	58,624	29,535	58,823	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	258,124	49,108	41,340	0	41,481	54.00
60.00	LABORATORY	330,520	24,329	20,480	0	20,550	60.00
65.00	RESPIRATORY THERAPY	39,571	18,064	15,207	0	15,259	65.00
66.00	PHYSICAL THERAPY	145,382	38,714	32,590	11,690	32,701	66.00
69.00	ELECTROCARDIOLOGY	6,869	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,699	19,051	16,038	0	16,092	71.00
72.00	IMP. DEV CHARGED TO PATIENT	9,182	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	188,568	29,263	24,634	0	24,718	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	396,498	58,559	49,296	0	49,464	88.00
90.00	CLINIC	67,106	18,611	15,667	0	15,721	90.00
91.00	EMERGENCY	210,265	24,908	20,968	15,335	21,039	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	69,636	20,596	17,338	0	17,397	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,002,002	694,218	567,690	358,972	556,431	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
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)	3,002,002	694,218	567,690	358,972	556,431	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	463,736					10.00
11.00	CAFETERIA	0	146,315				11.00
13.00	NURSING ADMINISTRATION	0	2,502	313,998			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	7,077	0	510,424		16.00
17.00	SOCIAL SERVICE	0	1,966	0	0	115,342	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	123,840	20,204	114,896	37,641	115,342	30.00
31.00	INTENSIVE CARE UNIT	12,421	3,252	18,494	3,713	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	327,475	13,769	78,299	8,366	0	44.00
45.00	NURSING FACILITY	0	38,170	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	7,911	44,991	41,567	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	7,065	0	121,064	0	54.00
60.00	LABORATORY	0	14,719	0	90,061	0	60.00
65.00	RESPIRATORY THERAPY	0	2,100	0	26,844	0	65.00
66.00	PHYSICAL THERAPY	0	9,170	0	26,776	0	66.00
69.00	ELECTROCARDIOLOGY	0	625	0	7,797	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,483	0	36,158	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	2,576	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,620	0	55,108	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	3,603	0	22,876	0	88.00
90.00	CLINIC	0	0	0	9,764	0	90.00
91.00	EMERGENCY	0	10,079	57,318	20,113	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	463,736	146,315	313,998	510,424	115,342	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
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)	463,736	146,315	313,998	510,424	115,342	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
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
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	2,802,199	0	2,802,199		30.00
31.00	INTENSIVE CARE UNIT	419,591	0	419,591		31.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	1,846,902	0	1,846,902		44.00
45.00	NURSING FACILITY	2,669,776	0	2,669,776		45.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,509,070	0	1,509,070		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	2,051,877	0	2,051,877		54.00
60.00	LABORATORY	2,464,509	0	2,464,509		60.00
65.00	RESPIRATORY THERAPY	352,164	0	352,164		65.00
66.00	PHYSICAL THERAPY	1,160,841	0	1,160,841		66.00
69.00	ELECTROCARDIOLOGY	56,103	0	56,103		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	996,094	0	996,094		71.00
72.00	IMP. DEV CHARGED TO PATIENT	66,314	0	66,314		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,445,326	0	1,445,326		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	2,936,154	0	2,936,154		88.00
90.00	CLINIC	525,592	0	525,592		90.00
91.00	EMERGENCY	1,629,354	0	1,629,354		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	538,724	0	538,724		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,470,590	0	23,470,590		118.00
	NONREIMBURSABLE COST CENTERS					
194.00	DR. OFFICE	0	0	0		194.00
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	23,470,590	0	23,470,590		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	94,598	29,531	124,129	0	5.00
6.00	MAINTENANCE & REPAIRS	0	29,927	9,342	39,269	0	6.00
7.00	OPERATION OF PLANT	0	19,560	6,106	25,666	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	13,516	4,219	17,735	0	8.00
9.00	HOUSEKEEPING	0	1,870	584	2,454	0	9.00
10.00	DIETARY	0	4,914	1,534	6,448	0	10.00
11.00	CAFETERIA	0	5,231	1,633	6,864	0	11.00
13.00	NURSING ADMINISTRATION	0	1,353	422	1,775	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	11,687	3,649	15,336	0	16.00
17.00	SOCIAL SERVICE	0	1,691	528	2,219	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	154,272	48,161	202,433	0	30.00
31.00	INTENSIVE CARE UNIT	0	14,086	4,397	18,483	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	90,382	28,215	118,597	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	68,603	21,416	90,019	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	48,377	15,102	63,479	0	54.00
60.00	LABORATORY	0	23,967	7,482	31,449	0	60.00
65.00	RESPIRATORY THERAPY	0	17,795	5,555	23,350	0	65.00
66.00	PHYSICAL THERAPY	0	38,137	11,906	50,043	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,768	5,859	24,627	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	28,828	8,999	37,827	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	57,687	18,008	75,695	0	88.00
90.00	CLINIC	0	18,334	5,723	24,057	0	90.00
91.00	EMERGENCY	0	24,537	7,660	32,197	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	20,289	6,334	26,623	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	808,409	252,365	1,060,774	0	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	808,409	252,365	1,060,774	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	124,129					5.00
6.00	MAINTENANCE & REPAIRS	4,135	43,404				6.00
7.00	OPERATION OF PLANT	3,263	1,241	30,170			7.00
8.00	LAUNDRY & LINEN SERVICE	1,988	858	614	21,195		8.00
9.00	HOUSEKEEPING	3,236	119	85	574	6,468	9.00
10.00	DIETARY	2,650	312	223	319	49	10.00
11.00	CAFETERIA	755	332	238	309	52	11.00
13.00	NURSING ADMINISTRATION	1,833	86	61	0	13	13.00
16.00	MEDICAL RECORDS & LIBRARY	2,808	742	531	0	116	16.00
17.00	SOCIAL SERVICE	648	107	77	0	17	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,008	9,792	7,006	7,176	1,539	30.00
31.00	INTENSIVE CARE UNIT	1,996	894	640	486	140	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,077	5,736	4,105	8,992	901	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,136	4,354	3,116	1,744	684	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	10,673	3,070	2,197	0	482	54.00
60.00	LABORATORY	13,666	1,521	1,088	0	239	60.00
65.00	RESPIRATORY THERAPY	1,636	1,129	808	0	177	65.00
66.00	PHYSICAL THERAPY	6,011	2,420	1,732	690	380	66.00
69.00	ELECTROCARDIOLOGY	284	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,404	1,191	852	0	187	71.00
72.00	IMP. DEV CHARGED TO PATIENT	380	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,797	1,830	1,309	0	287	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	16,397	3,661	2,620	0	575	88.00
90.00	CLINIC	2,775	1,164	833	0	183	90.00
91.00	EMERGENCY	8,694	1,557	1,114	905	245	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	2,879	1,288	921	0	202	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	124,129	43,404	30,170	21,195	6,468	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
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)	124,129	43,404	30,170	21,195	6,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	10,001					10.00
11.00	CAFETERIA	0	8,550				11.00
13.00	NURSING ADMINISTRATION	0	146	3,914			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	414	0	19,947		16.00
17.00	SOCIAL SERVICE	0	115	0	0	3,183	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,671	1,181	1,432	1,471	3,183	30.00
31.00	INTENSIVE CARE UNIT	268	190	231	145	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	7,062	805	976	327	0	44.00
45.00	NURSING FACILITY	0	2,228	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	462	561	1,624	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	413	0	4,733	0	54.00
60.00	LABORATORY	0	860	0	3,519	0	60.00
65.00	RESPIRATORY THERAPY	0	123	0	1,049	0	65.00
66.00	PHYSICAL THERAPY	0	536	0	1,046	0	66.00
69.00	ELECTROCARDIOLOGY	0	37	0	305	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87	0	1,413	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	101	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	153	0	2,153	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	211	0	894	0	88.00
90.00	CLINIC	0	0	0	381	0	90.00
91.00	EMERGENCY	0	589	714	786	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,001	8,550	3,914	19,947	3,183	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
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)	10,001	8,550	3,914	19,947	3,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
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
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	248,892	0	248,892		30.00
31.00	INTENSIVE CARE UNIT	23,473	0	23,473		31.00
43.00	NURSERY	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	153,578	0	153,578		44.00
45.00	NURSING FACILITY	2,228	0	2,228		45.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	109,700	0	109,700		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	85,047	0	85,047		54.00
60.00	LABORATORY	52,342	0	52,342		60.00
65.00	RESPIRATORY THERAPY	28,272	0	28,272		65.00
66.00	PHYSICAL THERAPY	62,858	0	62,858		66.00
69.00	ELECTROCARDIOLOGY	626	0	626		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,761	0	33,761		71.00
72.00	IMP. DEV CHARGED TO PATIENT	481	0	481		72.00
73.00	DRUGS CHARGED TO PATIENTS	51,356	0	51,356		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	100,053	0	100,053		88.00
90.00	CLINIC	29,393	0	29,393		90.00
91.00	EMERGENCY	46,801	0	46,801		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	31,913	0	31,913		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,060,774	0	1,060,774		118.00
	NONREIMBURSABLE COST CENTERS					
194.00	DR. OFFICE	0	0	0		194.00
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	1,060,774	0	1,060,774		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	76,501					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		76,501				2.00
4.00	EMPLOYEE BENEFITS	0	0	9,611,618			4.00
5.00	ADMINISTRATIVE & GENERAL	8,952	8,952	892,575	-3,002,002	17,836,982	5.00
6.00	MAINTENANCE & REPAIRS	2,832	2,832	235,016	0	594,211	6.00
7.00	OPERATION OF PLANT	1,851	1,851	0	0	468,915	7.00
8.00	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	285,630	8.00
9.00	HOUSEKEEPING	177	177	268,363	0	464,962	9.00
10.00	DIETARY	465	465	84,828	0	380,840	10.00
11.00	CAFETERIA	495	495	52,977	0	108,546	11.00
13.00	NURSING ADMINISTRATION	128	128	197,049	0	263,465	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,106	1,106	252,459	0	403,556	16.00
17.00	SOCIAL SERVICE	160	160	67,764	0	93,097	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,599	14,599	1,064,639	0	1,581,800	30.00
31.00	INTENSIVE CARE UNIT	1,333	1,333	210,856	0	286,794	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	8,553	8,553	569,386	0	873,259	44.00
45.00	NURSING FACILITY	0	0	0	-2,631,606	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,492	6,492	957,230	0	1,025,402	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	4,578	4,578	399,600	0	1,533,695	54.00
60.00	LABORATORY	2,268	2,268	747,210	0	1,963,850	60.00
65.00	RESPIRATORY THERAPY	1,684	1,684	110,874	0	235,119	65.00
66.00	PHYSICAL THERAPY	3,609	3,609	644,138	0	863,818	66.00
69.00	ELECTROCARDIOLOGY	0	0	33,012	0	40,812	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	44,166	0	776,573	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	0	54,556	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,728	2,728	213,366	0	1,120,415	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	5,459	5,459	1,534,316	0	2,355,858	88.00
90.00	CLINIC	1,735	1,735	195,064	0	398,723	90.00
91.00	EMERGENCY	2,322	2,322	572,779	0	1,249,329	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,920	1,920	263,951	0	413,757	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	76,501	76,501	9,611,618	-5,633,608	17,836,982	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	808,409	252,365	2,270,982		3,002,002	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.567300	3.298846	0.236275		0.168302	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		124,129	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.006959	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	64,717					6.00
7.00	OPERATION OF PLANT	1,851	62,866				7.00
8.00	LAUNDRY & LINEN SERVICE	1,279	1,279	257,056			8.00
9.00	HOUSEKEEPING	177	177	6,959	61,410		9.00
10.00	DIETARY	465	465	3,867	465	53,204	10.00
11.00	CAFETERIA	495	495	3,749	495	0	11.00
13.00	NURSING ADMINISTRATION	128	128	0	128	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,106	1,106	0	1,106	0	16.00
17.00	SOCIAL SERVICE	160	160	0	160	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,599	14,599	87,035	14,599	14,208	30.00
31.00	INTENSIVE CARE UNIT	1,333	1,333	5,897	1,333	1,425	31.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	8,553	8,553	109,047	8,553	37,571	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,492	6,492	21,150	6,492	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	4,578	4,578	0	4,578	0	54.00
60.00	LABORATORY	2,268	2,268	0	2,268	0	60.00
65.00	RESPIRATORY THERAPY	1,684	1,684	0	1,684	0	65.00
66.00	PHYSICAL THERAPY	3,609	3,609	8,371	3,609	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	0	1,776	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,728	2,728	0	2,728	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	5,459	5,459	0	5,459	0	88.00
90.00	CLINIC	1,735	1,735	0	1,735	0	90.00
91.00	EMERGENCY	2,322	2,322	10,981	2,322	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,920	1,920	0	1,920	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,717	62,866	257,056	61,410	53,204	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	694,218	567,690	358,972	556,431	463,736	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.726981	9.030159	1.396474	9.060918	8.716187	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	43,404	30,170	21,195	6,468	10,001	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.670674	0.479910	0.082453	0.105325	0.187975	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
		11.00	13.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	389,946					11.00
13.00	NURSING ADMINISTRATION	6,669	147,155				13.00
16.00	MEDICAL RECORDS & LIBRARY	18,861	0	49,730,649			16.00
17.00	SOCIAL SERVICE	5,239	0	0	100		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	53,846	53,846	3,667,303	100		30.00
31.00	INTENSIVE CARE UNIT	8,667	8,667	361,760	0		31.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	36,695	36,695	815,084	0		44.00
45.00	NURSING FACILITY	101,725	0	0	0		45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	21,085	21,085	4,049,809	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	18,828	0	11,796,150	0		54.00
60.00	LABORATORY	39,229	0	8,774,497	0		60.00
65.00	RESPIRATORY THERAPY	5,597	0	2,615,348	0		65.00
66.00	PHYSICAL THERAPY	24,439	0	2,608,763	0		66.00
69.00	ELECTROCARDIOLOGY	1,667	0	759,621	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,952	0	3,522,773	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	250,945	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	6,982	0	5,369,057	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	9,603	0	2,228,714	0		88.00
90.00	CLINIC	0	0	951,281	0		90.00
91.00	EMERGENCY	26,862	26,862	1,959,544	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	389,946	147,155	49,730,649	100		118.00
	NONREIMBURSABLE COST CENTERS						
194.00	DR. OFFICE	0	0	0	0		194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	146,315	313,998	510,424	115,342		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.375219	2.133791	0.010264	1,153.420000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	8,550	3,914	19,947	3,183		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.021926	0.026598	0.000401	31.830000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,802,199		2,802,199	0	0	30.00
31.00	INTENSIVE CARE UNIT	419,591		419,591	0	0	31.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,846,902		1,846,902	0	0	44.00
45.00	NURSING FACILITY	2,669,776		2,669,776	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,509,070		1,509,070	0	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0		0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	2,051,877		2,051,877	0	0	54.00
60.00	LABORATORY	2,464,509		2,464,509	0	0	60.00
65.00	RESPIRATORY THERAPY	352,164	0	352,164	0	0	65.00
66.00	PHYSICAL THERAPY	1,160,841	0	1,160,841	0	0	66.00
69.00	ELECTROCARDIOLOGY	56,103		56,103	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	996,094		996,094	0	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	66,314		66,314	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,445,326		1,445,326	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,936,154		2,936,154	0	0	88.00
90.00	CLINIC	525,592		525,592	0	0	90.00
91.00	EMERGENCY	1,629,354		1,629,354	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	658,039		658,039		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	538,724		538,724		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	24,128,629	0	24,128,629	0	0	200.00
201.00	Less Observation Beds	658,039		658,039		0	201.00
202.00	Total (see instructions)	23,470,590	0	23,470,590	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/16/2012 10:35 am

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	3,035,936		3,035,936			30.00
31.00	INTENSIVE CARE UNIT	361,760		361,760			31.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	815,084		815,084			44.00
45.00	NURSING FACILITY	3,528,288		3,528,288			45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	432,358	3,617,451	4,049,809	0.372627	0.000000	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	0.000000	52.00
54.00	RADIOLOGY - DIAGNOSTIC	1,195,935	10,600,215	11,796,150	0.173945	0.000000	54.00
60.00	LABORATORY	1,641,163	7,133,335	8,774,498	0.280872	0.000000	60.00
65.00	RESPIRATORY THERAPY	454,862	1,156,771	1,611,633	0.218514	0.000000	65.00
66.00	PHYSICAL THERAPY	949,130	1,659,633	2,608,763	0.444978	0.000000	66.00
69.00	ELECTROCARDIOLOGY	176,289	583,332	759,621	0.073857	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,648,786	2,877,701	4,526,487	0.220059	0.000000	71.00
72.00	IMP. DEV CHARGED TO PATIENT	1,470	249,475	250,945	0.264257	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,166,167	3,202,890	5,369,057	0.269196	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	2,228,714	2,228,714			88.00
90.00	CLINIC	0	951,281	951,281	0.552510	0.000000	90.00
91.00	EMERGENCY	155,176	1,804,368	1,959,544	0.831497	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	80,678	550,689	631,367	1.042245	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	16,643,082	36,615,855	53,258,937			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	16,643,082	36,615,855	53,258,937			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Hospital	Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMP. DEV CHARGED TO PATIENT	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
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
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/16/2012 10:35 am

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	109,700	4,049,809	0.027088	252,195	6,831	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	85,047	11,796,150	0.007210	943,881	6,805	54.00
60.00	LABORATORY	52,342	8,774,498	0.005965	1,302,028	7,767	60.00
65.00	RESPIRATORY THERAPY	28,272	1,611,633	0.017542	286,091	5,019	65.00
66.00	PHYSICAL THERAPY	62,858	2,608,763	0.024095	126,020	3,036	66.00
69.00	ELECTROCARDIOLOGY	626	759,621	0.000824	156,786	129	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,761	4,526,487	0.007459	1,077,873	8,040	71.00
72.00	IMP. DEV CHARGED TO PATIENT	481	250,945	0.001917	1,470	3	72.00
73.00	DRUGS CHARGED TO PATIENTS	51,356	5,369,057	0.009565	1,577,783	15,091	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	100,053	2,228,714	0.044893	0	0	88.00
90.00	CLINIC	29,393	951,281	0.030898	0	0	90.00
91.00	EMERGENCY	46,801	1,959,544	0.023884	130,879	3,126	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	631,367	0.000000	57,248	0	92.00
200.00	Total (lines 50-199)	600,690	45,517,869		5,912,254	55,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/16/2012 10:35 am
	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
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	IMP. DEV CHARGED TO PATIENT	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
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
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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/16/2012 10:35 am

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	4,049,809	0.000000	0.000000	252,195	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	11,796,150	0.000000	0.000000	943,881	54.00
60.00	LABORATORY	0	8,774,498	0.000000	0.000000	1,302,028	60.00
65.00	RESPIRATORY THERAPY	0	1,611,633	0.000000	0.000000	286,091	65.00
66.00	PHYSICAL THERAPY	0	2,608,763	0.000000	0.000000	126,020	66.00
69.00	ELECTROCARDIOLOGY	0	759,621	0.000000	0.000000	156,786	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,526,487	0.000000	0.000000	1,077,873	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	250,945	0.000000	0.000000	1,470	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,369,057	0.000000	0.000000	1,577,783	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	2,228,714	0.000000	0.000000	0	88.00
90.00	CLINIC	0	951,281	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	1,959,544	0.000000	0.000000	130,879	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	631,367	0.000000	0.000000	57,248	92.00
200.00	Total (lines 50-199)	0	45,517,869			5,912,254	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/16/2012 10:35 am

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
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	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
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
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am

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	0.372627	0	1,127,034	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	0	4,751,447	0		54.00
60.00	LABORATORY	0.280872	0	3,496,239	0		60.00
65.00	RESPIRATORY THERAPY	0.218514	0	350,117	0		65.00
66.00	PHYSICAL THERAPY	0.444978	0	674,945	0		66.00
69.00	ELECTROCARDIOLOGY	0.073857	0	268,106	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	0	1,329,141	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	0	133,905	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	0	1,214,660	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	0.552510	0	936,122	0		90.00
91.00	EMERGENCY	0.831497	0	527,267	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	0	255,690	0		92.00
200.00	Subtotal (see instructions)		0	15,064,673	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	15,064,673	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Costs PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	419,963	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	826,490	0		54.00
60.00	LABORATORY	0	981,996	0		60.00
65.00	RESPIRATORY THERAPY	0	76,505	0		65.00
66.00	PHYSICAL THERAPY	0	300,336	0		66.00
69.00	ELECTROCARDIOLOGY	0	19,802	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	292,489	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	35,385	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	326,982	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	517,217	0		90.00
91.00	EMERGENCY	0	438,421	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	266,492	0		92.00
200.00	Subtotal (see instructions)	0	4,502,078	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	4,502,078	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Swing Beds - SNF | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.372627	0	0	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	0	0	0		54.00
60.00	LABORATORY	0.280872	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.218514	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.444978	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.073857	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	0.552510	0	0	0		90.00
91.00	EMERGENCY	0.831497	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	0	0	0		92.00
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: 141311 | Component CCN: 145552 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Swing Beds - SNF | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	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
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
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

	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	0.372627	0	0	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	0	0	0		54.00
60.00	LABORATORY	0.280872	0	2,806	0		60.00
65.00	RESPIRATORY THERAPY	0.218514	0	134	0		65.00
66.00	PHYSICAL THERAPY	0.444978	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.073857	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	0	495	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	0.552510	0	0	0		90.00
91.00	EMERGENCY	0.831497	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	0	0	0		92.00
200.00	Subtotal (see instructions)		0	3,435	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	3,435	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

	Cost Center Description	Costs PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	788	0		60.00
65.00	RESPIRATORY THERAPY	0	29	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	133	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	950	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	950	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am

Title XIX | 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	0.000000	0	0	866,760		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	1,950,071		54.00
60.00	LABORATORY	0.000000	0	0	976,096		60.00
65.00	RESPIRATORY THERAPY	0.000000	0	0	149,008		65.00
66.00	PHYSICAL THERAPY	0.000000	0	0	232,254		66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	63,401		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	649,194		71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	0	655,567		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	0.000000	0	0	565,270		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0		92.00
200.00	Subtotal (see instructions)		0	0	6,107,621		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	6,107,621		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/16/2012 10:35 am
	Title XIX	Hospital	Cost

	Cost Center Description	Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMP. DEV CHARGED TO PATIENT	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
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
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: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/16/2012 10:35 am
	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)	3,296	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,296	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)	3,296	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,864	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	163.33	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	166.99	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,802,199	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,802,199	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,667,303	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,667,303	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.764103	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,112.65	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,802,199	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)	850.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,584,736	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,584,736	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	419,591	253	1,658.46	201	333,350	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)	1,584,840	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,502,926	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	774	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	850.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	658,039	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/16/2012 10:35 am

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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 10:35 am

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		1,537,800		30.00
31.00	INTENSIVE CARE UNIT		273,360		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.372627	252,195	93,975	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	943,881	164,183	54.00
60.00	LABORATORY	0.280872	1,302,028	365,703	60.00
65.00	RESPIRATORY THERAPY	0.218514	286,091	62,515	65.00
66.00	PHYSICAL THERAPY	0.444978	126,020	56,076	66.00
69.00	ELECTROCARDIOLOGY	0.073857	156,786	11,580	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	1,077,873	237,196	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	1,470	388	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	1,577,783	424,733	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	0.552510	0	0	90.00
91.00	EMERGENCY	0.831497	130,879	108,825	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	57,248	59,666	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,912,254	1,584,840	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)		5,912,254		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Swing Beds - SNF | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.372627	0	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	0	0	54.00
60.00	LABORATORY	0.280872	0	0	60.00
65.00	RESPIRATORY THERAPY	0.218514	0	0	65.00
66.00	PHYSICAL THERAPY	0.444978	0	0	66.00
69.00	ELECTROCARDIOLOGY	0.073857	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	0	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	0.552510	0	0	90.00
91.00	EMERGENCY	0.831497	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 141311	Period: From 07/01/2010	Worksheet D-3
	Component CCN:	To 06/30/2011	Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

	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		268,901		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.372627	0	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.173945	30,608	5,324	54.00
60.00	LABORATORY	0.280872	90,421	25,397	60.00
65.00	RESPIRATORY THERAPY	0.218514	61,003	13,330	65.00
66.00	PHYSICAL THERAPY	0.444978	657,226	292,451	66.00
69.00	ELECTROCARDIOLOGY	0.073857	5,264	389	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.220059	222,865	49,043	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.264257	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.269196	61,164	16,465	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	0.552510	0	0	90.00
91.00	EMERGENCY	0.831497	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.042245	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,128,551	402,399	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,128,551		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/16/2012 10:35 am
	Title XIX	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		487,037		30.00
31.00	INTENSIVE CARE UNIT		28,560		31.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	64,983	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	102,945	0	54.00
60.00	LABORATORY	0.000000	110,469	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	65,106	0	65.00
66.00	PHYSICAL THERAPY	0.000000	8,687	0	66.00
69.00	ELECTROCARDIOLOGY	0.000000	6,081	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	326,359	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	215,489	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.000000	15,919	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		916,038	0	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)		916,038		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141311 | Component CCN: 140000 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 10:35 am

Title XIX | Swing Beds - NF | 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		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	0	0	50.00
52.00	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	54.00
60.00	LABORATORY	0.000000	0	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	0.000000	0	0	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMP. DEV CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,502,078	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)	4,502,078	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)	4,547,099	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)	76,512	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,330,000	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,140,587	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,140,587	30.00
31.00	Primary payer payments	1,301	31.00
32.00	Subtotal (line 30 minus line 31)	2,139,286	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)	588,867	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	588,867	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,728,153	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,728,153	40.00
41.00	Interim payments	3,159,180	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)	-431,027	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	950	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	950	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)	960	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)	423	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	537	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)	537	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	537	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	537	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	537	40.00
41.00	Interim payments	537	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)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,746,080		3,034,280	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	01/25/2011	53,500	01/25/2011	124,900	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		53,500		124,900	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,799,580		3,159,180	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		338,755		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		431,027	6.02
7.00	Total Medicare program liability (see instructions)		3,138,335		2,728,153	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: 141311 | Component CCN: 145552 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Swing Beds - SNF | 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		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	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: 141311 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

		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		751,042		537	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		751,042		537	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		751,042		0	6.02
7.00	Total Medicare program liability (see instructions)		0		537	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: 141311 Component CCN: 145552	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Swing Beds - SNF	PPS

		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)	0	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)			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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	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)	0	0	19.00
20.00	Interim payments	0	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)	0	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 - SWING BEDS	Provider CCN: 141311 Component CCN: 140000	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/16/2012 10:35 am
	Title XIX	Swing Beds - NF	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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
17.00	Reimbursable bad debts (see instructions)	0		17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	0		19.00
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	3,502,926	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	3,502,926	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	3,537,955	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)	3,537,955	19.00
20.00	Deductibles (exclude professional component)	472,569	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)	3,065,386	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,065,386	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	72,949	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	72,949	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	3,138,335	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)	3,138,335	30.00
31.00	Interim payments	2,799,580	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)	338,755	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Skilled Nursing Facility	

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/16/2012 10:35 am

		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	1,328,364	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,548,571	0	0	0	4.00
5.00	Other receivable	76,226	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,887,134	0	0	0	6.00
7.00	Inventory	310,892	0	0	0	7.00
8.00	Prepaid expenses	160,276	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,537,195	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,026,275	0	0	0	15.00
16.00	Accumulated depreciation	-16,002,668	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,023,607	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,408	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,532,454	0	0	0	33.00
34.00	Other assets	811,689	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,351,551	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,912,353	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,862,568	0	0	0	37.00
38.00	Salaries, wages, and fees payable	322,037	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	493,877	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	498,263	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,176,745	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,947,577	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,947,577	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,124,322	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,788,031				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)	12,788,031	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,912,353	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/16/2012 10:35 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		12,392,428		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		836,225				2.00
3.00	Total (sum of line 1 and line 2)		13,228,653		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)		13,228,653		0		11.00
12.00	Deductions (debit adjustments) (specify)	1,351,773		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)		1,351,773		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,876,880		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/16/2012 10:35 am

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/16/2012 10:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,667,303		3,667,303	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	815,084		815,084	7.00
8.00	NURSING FACILITY	3,528,288		3,528,288	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,010,675		8,010,675	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	361,760		361,760	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)	361,760		361,760	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,372,435		8,372,435	17.00
18.00	Ancillary services	8,821,128	33,836,660	42,657,788	18.00
19.00	Outpatient services	0	554,521	554,521	19.00
20.00	RURAL HEALTH CLINIC	0	2,228,714	2,228,714	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	438,828	4,130,784	4,569,612	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,632,391	40,750,679	58,383,070	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,266,224		29.00
30.00	BAD DEBT	1,441,204			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,441,204		36.00
37.00	WAYFAIR	2,675,038			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)		2,675,038		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,032,390		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141311	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/16/2012 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,383,070	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,444,287	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,938,783	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,032,390	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,906,393	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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 REVENUE	209,013	24.00
24.01	NON-OPERATING REVENUE	249,107	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	458,120	25.00
26.00	Total (line 5 plus line 25)	4,364,513	26.00
27.00	WAYFAIR	3,528,288	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,528,288	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	836,225	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147612 | Date/Time Prepared: 1/16/2012 10:35 am

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	163,951	0	0	0	60,818	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	100,000	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	263,951	0	0	0	60,818	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147612 | Date/Time Prepared: 1/16/2012 10:35 am

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	224,769	0	224,769	0	224,769	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	100,000	0	100,000	0	100,000	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	324,769	0	324,769	0	324,769	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I | Date/Time Prepared: 1/16/2012 10:35 am

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	224,769	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	100,000	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	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	324,769	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I | Date/Time Prepared: 1/16/2012 10:35 am

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	224,769	224,769			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	100,000	224,769	324,769		6.00
7.00	Physical Therapy	0	0	0		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	0	0	0		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	0	0	0		23.00
24.00	Total (sum of lines 1-23)	100,000		324,769		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part II Date/Time Prepared: 1/16/2012 10:35 am

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-224,769	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	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-224,769	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: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part II | Date/Time Prepared: 1/16/2012 10:35 am

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		Administrative & General (ACCUM. COST)	
		5.00	
	GENERAL SERVICE COST CENTERS		
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	100,000	5.00
	HHA REIMBURSABLE SERVICES		
6.00	Skilled Nursing Care	100,000	6.00
7.00	Physical Therapy	0	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	0	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	0	23.00
24.00	Total (sum of lines 1-23)	100,000	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	224,769	25.00
26.00	Unit Cost Multiplier	2.247690	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

HHA CCN: 147612 | Home Health Agency I | PPS

			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	20,289	6,334	62,365	88,988	1.00
2.00	Skilled Nursing Care	324,769	0	0	0	324,769	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	324,769	20,289	6,334	62,365	413,757	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

HHA CCN: 147612 | Home Health Agency I | PPS

		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	14,977	20,596	17,338	0	17,397	1.00
2.00	Skilled Nursing Care	54,659	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	69,636	20,596	17,338	0	17,397	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

HHA CCN: 147612 | Home Health Agency I | PPS

		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						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: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/16/2012 10:35 am

HHA CCN: 147612 | Home Health Agency I | PPS

		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	159,296	0	159,296			1.00
2.00	Skilled Nursing Care	379,428	0	379,428	159,296	538,724	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	538,724	0	538,724	159,296	538,724	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.				0.419832		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part II | Date/Time Prepared: 1/16/2012 10:35 am

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		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,920	1,920	263,951	0	88,988	1.00
2.00	Skilled Nursing Care	0	0	0	0	324,769	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,920	1,920	263,951		413,757	20.00
21.00	Total cost to be allocated	20,289	6,334	62,365		69,636	21.00
22.00	Unit cost multiplier	10.567187	3.298958	0.236275		0.168302	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part II Date/Time Prepared: 1/16/2012 10:35 am
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		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	1,920	1,920	0	1,920	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	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,920	1,920	0	1,920	0	20.00
21.00	Total cost to be allocated	20,596	17,338	0	17,397	0	21.00
22.00	Unit cost multiplier	10.727083	9.030208	0.000000	9.060938	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part II | Date/Time Prepared: 1/16/2012 10:35 am

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		CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
		11.00	13.00	16.00	17.00		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others	0	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/16/2012 10:35 am

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	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	538,724		538,724	2,795	1.00
2.00	Physical Therapy	3.00	0	0	0	914	2.00
3.00	Occupational Therapy	4.00	0	0	0	130	3.00
4.00	Speech Pathology	5.00	0	0	0	51	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	0		0	1	6.00
7.00	Total (sum of lines 1-6)		538,724	0	538,724	3,891	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		14999	0	0		8.00
9.00	Physical Therapy		14999	0	0		9.00
10.00	Occupational Therapy		14999	0	0		10.00
11.00	Speech Pathology		14999	0	0		11.00
12.00	Medical Social Services		14999	0	0		12.00
13.00	Home Health Aide		14999	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	70,000	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	0.444978	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.220059	0	0	4.00
5.00	Cost of Drugs	73.00	0.269196	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141311 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/16/2012 10:35 am

HHA CCN: 147612 | 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	192.75	996	1,165			1.00
2.00	Physical Therapy	0.00	465	333			2.00
3.00	Occupational Therapy	0.00	78	46			3.00
4.00	Speech Pathology	0.00	31	18			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	0.00	0	1			6.00
7.00	Total (sum of lines 1-6)		1,570	1,563			7.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	26,196	35,898	0		15.00
16.00	Cost of Drugs	0.000000	0	0	0		16.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/16/2012 10:35 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	191,979	224,554		416,533		1.00
2.00	Physical Therapy	0	0		0		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	0	0		0		6.00
7.00	Total (sum of lines 1-6)	191,979	224,554		416,533		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	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B 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: 141311 HHA CCN: 147612	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 1/16/2012 10:35 am
	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	199,023	207,870	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)	199,023	207,870	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	199,023	207,870	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	230,680	231,656	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,738	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	4,027	3,885	13.00
14.00	Total PPS Reimbursement - PEP Episodes	334	1,136	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	496	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)	235,041	238,911	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	235,041	238,911	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	235,041	238,911	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)	235,041	238,911	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	235,041	238,911	31.00
32.00	Interim payments (see instructions)	235,041	238,911	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: 141311 HHA CCN: 147612	Period: From 07/01/2010 To 06/30/2011	Worksheet H-5 Date/Time Prepared: 1/16/2012 10:35 am
		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		235,041		238,911	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)		235,041		238,911	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)		235,041		238,911	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141311 | Component CCN: 148500 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/16/2012 10:35 am

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	912,392	0	912,392	0	912,392	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	184,931	0	184,931	0	184,931	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,097,323	0	1,097,323	0	1,097,323	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,097,323	0	1,097,323	0	1,097,323	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	0	0	0	0	29.00
30.00	Administrative Costs	436,993	389,013	826,006	-5,683	820,323	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	436,993	389,013	826,006	-5,683	820,323	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,534,316	389,013	1,923,329	-5,683	1,917,646	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	912,392		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	184,931		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	1,097,323		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,097,323		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	0	0		29.00
30.00	Administrative Costs	0	820,323		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	820,323		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,917,646		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141311 | Component CCN: 148500 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-2 | Date/Time Prepared: 1/16/2012 10:35 am

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.91	11,137	4,200	12,222		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.67	6,484	2,100	3,507		3.00
4.00	Subtotal (sum of lines 1-3)	4.58	17,621		15,729	17,621	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)	4.58	17,621			17,621	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)					1,097,323	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)					1,097,323	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)					820,323	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,018,508	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,838,831	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,838,831	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,838,831	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,936,154	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,936,154	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)		2,936,154	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		17,621	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)		17,621	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		166.63	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	166.63	166.63	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,812	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	968,454	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	968,454	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		716,682	16.04
16.05	Total program cost (see instructions)	0	716,682	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		72,602	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		716,682	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)		716,682	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)		716,682	26.00
27.00	Interim payments		638,181	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)		78,501	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: 141311 Component CCN: 148500	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/16/2012 10:35 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		638,181	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		638,181	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		78,501	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		716,682	7.00

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