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: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/29/2012 10:28 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 3/29/2012 Time: 10:28 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 HANNIBAL REGIONAL HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 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.

Encryption Information

ECR: Date: 3/29/2012 Time: 10:28 am
RkjhAmdkmtwBqVUyl5Kz8gFcXjJZQ0
PCY.m0NZuzH1yd.WIN9sJ10W7ZFK8b
RXoh1kEVlY06gk4p

PI: Date: 3/29/2012 Time: 10:28 am
q49EKl9wq3mTu1l9rlE23WxyEiUNQ1
zqjjp0bYOaKbm7w3bPLtu5qOoyq8o5
iUwK75GX2j0GO8eV

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	778,054	-100,987	0	0	1.00
2.00	Subprovider - IPF	0	21,371	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		11,639		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		6,711		0	10.01
10.02	RURAL HEALTH CLINIC III III	0		13,551		0	10.02
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	799,425	-69,086	0	0	200.00

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

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

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: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/29/2012 10:17 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 3/29/2012 Time: 10:17 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 HANNIBAL REGIONAL HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 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.

Encryption Information

ECR: Date: 3/29/2012 Time: 10:17 am
pA9Fk935WjJmZEkr26J3GeGcr:PzF0
eOpR:0rN:njlxTPIwS5eH0GhN:8E8H
7H.E18bXVZ0chhUQ

PI: Date: 3/29/2012 Time: 10:17 am
bW5z5b:u71.BuXYwtl9cXokyUswl41
dudb00XG4gYfDVEJmN8J3N:HUdF6oj
fr787fgGUS0F1qDR

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	778,054	-100,987	0	0	1.00
2.00	Subprovider - IPF	0	21,371	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		11,639		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		6,711		0	10.01
10.02	RURAL HEALTH CLINIC III III	0		13,551		0	10.02
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	799,425	-69,086	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: HIGHWAY 36, 6000 HOSPITAL DRIVE	PO Box:			1.00
2.00	City: HANNIBAL	State: MO	Zip Code: 63401-	County: MARION	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	HANNIBAL REGIONAL HOSPITAL	260025	99926	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANNIBAL REGIONAL - PSYCH	26S025	99926	4	10/01/1983	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HANNIBAL REGIONAL - HHA	267282	99926		04/10/1990	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	HANNIBAL REG - SHELBINA	268512	99926		06/11/1997	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC 1	HANNIBAL REG - LAGRANGE	263984	99926		04/03/1992	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC 2	HANNIBAL REG - MONROE CITY	268513	99926		06/11/1997	N	O	O	15.02
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2010	09/30/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	1,622	0	124	0	1,598	244	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

		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.	10/01/2010	09/30/2011	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

					1.00	
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	86.00
				V	XIX	
				1.00	2.00	
	Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00
	Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					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.			Y		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1		118.00
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.			2,000,000	6,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.			Y	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00
	Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

		Part A	Part B	
		1.00	2.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)			
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	SUBPROVIDER	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HOME HEALTH AGENCY	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 3/29/2012 10:16 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	01/24/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 3/29/2012 10:16 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					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 3/29/2012 10:16 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)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/24/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			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.			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:			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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 3/29/2012 10:16 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	83	30,295	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		83	30,295	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		91	33,215	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	14	3,990			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	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
26.01	RURAL HEALTH CLINIC II	88.01					26.01
26.02	RURAL HEALTH CLINIC III	88.02					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		105				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 3/29/2012 10:16 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	10,728	1,361	16,515		1.00
2.00	HMO		559	1,598			2.00
3.00	HMO IPF		30	78			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	10,728	1,361	16,515		7.00
8.00	INTENSIVE CARE UNIT	0	1,408	245	2,177		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		140	1,502		13.00
14.00	Total (see instructions)	0	12,136	1,746	20,194		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	704	749	2,167		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	0	4,771	0	7,619		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	1,648	228	5,464		26.00
26.01	RURAL HEALTH CLINIC II	0	899	576	3,683		26.01
26.02	RURAL HEALTH CLINIC III	0	1,611	228	5,378		26.02
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	365		28.00
28.01	SUBPROVIDER - IPF				0		28.01
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	176		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 3/29/2012 10:16 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	2,662	1.00
2.00	HMO					163	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	789.16	0.00	0	2,662	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	12.51	0.00	0	101	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	0.00	14.15	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	9.41	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	6.10	0.00			26.01
26.02	RURAL HEALTH CLINIC III	0.00	8.29	0.00			26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	839.62	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 3/29/2012 10:16 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)	789	4,974		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)	789	4,974		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	148	365		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
26.01	RURAL HEALTH CLINIC II				26.01
26.02	RURAL HEALTH CLINIC III				26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.01	SUBPROVIDER - IPF				28.01
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 3/29/2012 10:16 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	49,362,653	0	49,362,653	1,746,420.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		249,191	0	249,191	994.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		5,738,178	0	5,738,178	40,813.00	5.00
6.00	Non-physician-Part B		811,926	0	811,926	41,913.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		9,908,609	0	9,908,609	267,516.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		4,760	0	4,760	67.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		581,098	0	581,098	1,721.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		12,427,547	0	12,427,547		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		2,364,900	0	2,364,900		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		12,901	0	12,901		22.00
23.00	Physician Part B		529,959	0	529,959		23.00
24.00	Wage-related costs (RHC/FQHC)		348,665	0	348,665		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	470,378	0	470,378	20,355.00	26.00
27.00	Administrative & General	5.00	8,081,551	0	8,081,551	291,587.00	27.00
28.00	Administrative & General under contract (see inst.)		500,000	0	500,000	2,500.00	28.00
29.00	Maintenance & Repairs	6.00	210,464	0	210,464	16,530.00	29.00
30.00	Operation of Plant	7.00	634,401	0	634,401	32,317.00	30.00
31.00	Laundry & Linen Service	8.00	27,993	0	27,993	2,879.00	31.00
32.00	Housekeeping	9.00	554,356	0	554,356	54,522.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	760,465	0	760,465	58,136.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	476,800	0	476,800	17,479.00	38.00
39.00	Central Services and Supply	14.00	120,446	0	120,446	7,500.00	39.00
40.00	Pharmacy	15.00	1,550,040	0	1,550,040	48,778.00	40.00
41.00	Medical Records & Medical Records Library	16.00	647,114	0	647,114	38,207.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part II | Date/Time Prepared: 3/29/2012 10:16 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	28.27		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A	250.70		4.00
4.01	Physicians - Part A - direct teaching	0.00		4.01
5.00	Physician-Part B	140.60		5.00
6.00	Non-physician-Part B	19.37		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	0.00		9.00
10.00	Excluded area salaries (see instructions)	37.04		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	71.04		11.00
12.00	Management and administrative services	0.00		12.00
13.00	Contract labor: physician-Part A	337.65		13.00
14.00	Home office salaries & wage-related costs	0.00		14.00
15.00	Home office: physician Part A	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	23.11		26.00
27.00	Administrative & General	27.72		27.00
28.00	Administrative & General under contract (see inst.)	200.00		28.00
29.00	Maintenance & Repairs	12.73		29.00
30.00	Operation of Plant	19.63		30.00
31.00	Laundry & Linen Service	9.72		31.00
32.00	Housekeeping	10.17		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	13.08		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	0.00		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	27.28		38.00
39.00	Central Services and Supply	16.06		39.00
40.00	Pharmacy	31.78		40.00
41.00	Medical Records & Medical Records Library	16.94		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 3/29/2012 10:16 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		43,312,549	0	43,312,549	1,666,194.00	1.00
2.00	Excluded area salaries (see instructions)		9,908,609	0	9,908,609	267,516.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,403,940	0	33,403,940	1,398,678.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		585,858	0	585,858	1,788.00	4.00
5.00	Subtotal wage-related costs (see inst.)		12,440,448	0	12,440,448	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		46,430,246	0	46,430,246	1,400,466.00	6.00
7.00	Total overhead cost (see instructions)		14,034,008	0	14,034,008	590,790.00	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 3/29/2012 10:16 am

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	25.99		1.00
2.00	Excluded area salaries (see instructions)	37.04		2.00
3.00	Subtotal salaries (line 1 minus line 2)	23.88		3.00
4.00	Subtotal other wages & related costs (see inst.)	327.66		4.00
5.00	Subtotal wage-related costs (see inst.)	37.24		5.00
6.00	Total (sum of lines 3 thru 5)	33.15		6.00
7.00	Total overhead cost (see instructions)	23.75		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part IV Date/Time Prepared: 3/29/2012 10:16 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	2,347,985	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)	6,959,775	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)	46,783	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)	138,815	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	1,797	14.00
15.00	'Workers' Compensation Insurance	359,717	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	2,417,720	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	50,754	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	104,201	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,427,547	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-3 Part V Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,760	67	1.00
2.00	Hospital	4,760	67	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 260025 | Component CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-4 | Date/Time Prepared: 3/29/2012 10:16 am

Home Health Agency I | PPS

					1.00		
0.00	County				MARION		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,815	0	44	1,859	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	380.00	38.00	166.00	584.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			3.06	0.00	3.06	4.00
5.00	Other Administrative Personnel			0.83	0.00	0.83	5.00
6.00	Direct Nursing Service			5.83	0.00	5.83	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.26	0.00	2.26	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.43	0.00	0.43	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.30	0.00	0.30	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.05	0.00	0.05	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.89	0.00	0.89	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.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99926			20.00
20.01				99914			20.01
		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	2,283	49	94	45	2,471	21.00
22.00	Skilled Nursing Visit Charges	331,035	7,105	13,630	6,525	358,295	22.00
23.00	Physical Therapy Visits	1,366	4	19	15	1,404	23.00
24.00	Physical Therapy Visit Charges	211,730	620	2,945	2,325	217,620	24.00
25.00	Occupational Therapy Visits	296	1	5	11	313	25.00
26.00	Occupational Therapy Visit Charges	45,880	155	775	1,705	48,515	26.00
27.00	Speech Pathology Visits	80	0	0	0	80	27.00
28.00	Speech Pathology Visit Charges	12,400	0	0	0	12,400	28.00
29.00	Medical Social Service Visits	17	0	0	0	17	29.00
30.00	Medical Social Service Visit Charges	2,635	0	0	0	2,635	30.00
31.00	Home Health Aide Visits	485	0	1	0	486	31.00
32.00	Home Health Aide Visit Charges	33,950	0	70	0	34,020	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,527	54	119	71	4,771	33.00
34.00	Other Charges	23,877	1,025	816	98	25,816	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	661,507	8,905	18,236	10,653	699,301	35.00
36.00	Total Number of Episodes (standard/non outlier)	343		38	6	387	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	3,091	368	185	120	3,764	38.00

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

Provider CCN: 260025 Component CCN: 268512

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 3/29/2012 10:16 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	400 S. CENTER STREET	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	SHELBINA MO	63468 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			08:00	17:00	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	SHELBINA FAMILY PRACTICE	268512 14.00

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN:268512	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 am
		Rural Health Clinic (RHC) I	Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		SHELBY				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 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	08:00	17:00	08:00	17:00		11.00

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

Provider CCN: 260025 Component CCN: 268512

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 3/29/2012 10:16 am

Rural Health Clinic (RHC) I

Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:00	12:00		11.00

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

Provider CCN: 260025 Component CCN: 263984 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-8 | Date/Time Prepared: 3/29/2012 10:16 am

				Rural Health Clinic (RHC) II	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1802 ELM STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	CANTON		MO	63435	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			08:00	17:00	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		CANTON-LAGRANGE MEDICAL CLINIC		263984	14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

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

Provider CCN: 260025 Component CCN: 263984

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 3/29/2012 10:16 am

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		LEWIS				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 am
		Rural Health Clinic (RHC) II	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 am
		Rural Health Clinic (RHC) II	Cost

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

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

Provider CCN: 260025 Component CCN: 268513

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 3/29/2012 10:16 am

Rural Health Clinic (RHC) III

Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			821 BUSINESS HWYS 24 & 36		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	MONROE CITY		MO	63456	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			08:00	17:00	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		MONROE CITY FAMILY PRACTICE		268513	14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

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

Provider CCN: 260025 Component CCN: 268513

Period: From 10/01/2010 To 09/30/2011

Worksheet S-8

Date/Time Prepared: 3/29/2012 10:16 am

Rural Health Clinic (RHC) III

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		MONROE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 am
		Rural Health Clinic (RHC) III	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/29/2012 10:16 am
		Rural Health Clinic (RHC) III	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet S-10 | Date/Time Prepared: 3/29/2012 10:16 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)	0.349383	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,155,315	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,418,491	5.00
6.00	Medicaid charges	29,281,064	6.00
7.00	Medicaid cost (line 1 times line 6)	10,230,306	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	5,269,486	1,261,993	6,531,479	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,841,069	440,919	2,281,988	21.00
22.00	Partial payment by patients approved for charity care	51,421	752	52,173	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,789,648	440,167	2,229,815	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)	6,484,985	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	563,355	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	5,921,630	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	2,068,917	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	4,298,732	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,298,732	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A | Date/Time Prepared: 3/29/2012 10:16 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	NEW CAP REL COSTS-BLDG & FIXT		3,556,214	3,556,214	1,134,327	4,690,541	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		4,195,620	4,195,620	-910,637	3,284,983	2.00
4.00	EMPLOYEE BENEFITS	470,378	10,456,533	10,926,911	0	10,926,911	4.00
5.00	ADMINISTRATIVE & GENERAL	8,081,551	7,788,550	15,870,101	-1,490,648	14,379,453	5.00
6.00	MAINTENANCE & REPAIRS	210,464	53,308	263,772	0	263,772	6.00
7.00	OPERATION OF PLANT	634,401	1,430,797	2,065,198	0	2,065,198	7.00
8.00	LAUNDRY & LINEN SERVICE	27,993	263,292	291,285	0	291,285	8.00
9.00	HOUSEKEEPING	554,356	210,416	764,772	0	764,772	9.00
10.00	DIETARY	760,465	766,009	1,526,474	0	1,526,474	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	476,800	84,769	561,569	0	561,569	13.00
14.00	CENTRAL SERVICES & SUPPLY	120,446	153,599	274,045	-15,311	258,734	14.00
15.00	PHARMACY	1,550,040	673,409	2,223,449	0	2,223,449	15.00
16.00	MEDICAL RECORDS & LIBRARY	647,114	441,247	1,088,361	0	1,088,361	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,031,165	993,634	6,024,799	41,245	6,066,044	30.00
31.00	INTENSIVE CARE UNIT	1,663,702	548,186	2,211,888	13,106	2,224,994	31.00
40.00	SUBPROVIDER - IPF	754,076	126,130	880,206	0	880,206	40.00
43.00	NURSERY	241,877	120,216	362,093	5,075	367,168	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	908,729	675,068	1,583,797	-437,451	1,146,346	50.00
51.00	RECOVERY ROOM	738,040	127,238	865,278	0	865,278	51.00
52.00	DELIVERY ROOM & LABOR ROOM	739,246	153,411	892,657	5,072	897,729	52.00
53.00	ANESTHESIOLOGY	2,027,345	1,395,468	3,422,813	253,215	3,676,028	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,168,518	596,838	1,765,356	602,617	2,367,973	54.00
56.00	RADIOISOTOPE	94,689	87,787	182,476	0	182,476	56.00
57.00	CT SCAN	259,501	190,950	450,451	203,035	653,486	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	61,199	124,035	185,234	0	185,234	58.00
60.00	LABORATORY	1,232,927	2,265,740	3,498,667	122,820	3,621,487	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	102,594	709,640	812,234	0	812,234	62.00
65.00	RESPIRATORY THERAPY	735,580	223,666	959,246	30,707	989,953	65.00
66.00	PHYSICAL THERAPY	1,512,387	422,552	1,934,939	0	1,934,939	66.00
68.00	SPEECH PATHOLOGY	220,147	44,022	264,169	0	264,169	68.00
69.00	ELECTROCARDIOLOGY	1,028,867	1,056,016	2,084,883	-377,260	1,707,623	69.00
70.00	ELECTROENCEPHALOGRAPHY	141,475	31,131	172,606	0	172,606	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,649,703	6,649,703	0	6,649,703	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	814,711	814,711	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,802,109	2,802,109	0	2,802,109	73.00
76.00	CANCER CENTER	632,489	662,438	1,294,927	0	1,294,927	76.00
76.01	DIABETES CENTER	45,103	11,429	56,532	0	56,532	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	545,974	190,297	736,271	0	736,271	88.00
88.01	RURAL HEALTH CLINIC II	414,762	102,125	516,887	0	516,887	88.01
88.02	RURAL HEALTH CLINIC III	516,801	188,613	705,414	0	705,414	88.02
91.00	EMERGENCY	4,891,799	1,308,161	6,199,960	0	6,199,960	91.00
91.01	OUTPATIENT PSYCH	946,319	190,557	1,136,876	0	1,136,876	91.01
91.02	WOUND CARE	18,801	4,430	23,231	0	23,231	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	812,473	269,266	1,081,739	0	1,081,739	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,020,593	52,344,619	93,365,212	-5,377	93,359,835	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	7,474,431	1,901,109	9,375,540	5,377	9,380,917	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	867,629	358,556	1,226,185	0	1,226,185	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	0	0	0	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	49,362,653	54,604,284	103,966,937	0	103,966,937	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-190,982	4,499,559		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,284,983		2.00
4.00	EMPLOYEE BENEFITS	-1,511,945	9,414,966		4.00
5.00	ADMINISTRATIVE & GENERAL	3,973,000	18,352,453		5.00
6.00	MAINTENANCE & REPAIRS	0	263,772		6.00
7.00	OPERATION OF PLANT	-11,845	2,053,353		7.00
8.00	LAUNDRY & LINEN SERVICE	0	291,285		8.00
9.00	HOUSEKEEPING	0	764,772		9.00
10.00	DIETARY	-543,867	982,607		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	561,569		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	258,734		14.00
15.00	PHARMACY	-4,760	2,218,689		15.00
16.00	MEDICAL RECORDS & LIBRARY	-59,281	1,029,080		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-4,836	6,061,208		30.00
31.00	INTENSIVE CARE UNIT	0	2,224,994		31.00
40.00	SUBPROVIDER - IPF	0	880,206		40.00
43.00	NURSERY	-1,362	365,806		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,146,346		50.00
51.00	RECOVERY ROOM	0	865,278		51.00
52.00	DELIVERY ROOM & LABOR ROOM	-605	897,124		52.00
53.00	ANESTHESIOLOGY	-3,074,832	601,196		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-672	2,367,301		54.00
56.00	RADIOISOTOPE	0	182,476		56.00
57.00	CT SCAN	0	653,486		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	185,234		58.00
60.00	LABORATORY	-352,864	3,268,623		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	812,234		62.00
65.00	RESPIRATORY THERAPY	0	989,953		65.00
66.00	PHYSICAL THERAPY	-104,399	1,830,540		66.00
68.00	SPEECH PATHOLOGY	-144,748	119,421		68.00
69.00	ELECTROCARDIOLOGY	-32,969	1,674,654		69.00
70.00	ELECTROENCEPHALOGRAPHY	-14,072	158,534		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,649,703		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	814,711		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,802,109		73.00
76.00	CANCER CENTER	-46,031	1,248,896		76.00
76.01	DIABETES CENTER	0	56,532		76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	736,271		88.00
88.01	RURAL HEALTH CLINIC II	0	516,887		88.01
88.02	RURAL HEALTH CLINIC III	0	705,414		88.02
91.00	EMERGENCY	-3,554,993	2,644,967		91.00
91.01	OUTPATIENT PSYCH	-444,074	692,802		91.01
91.02	WOUND CARE	0	23,231		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	FAMILY PRACTICE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	1,081,739		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-6,126,137	87,233,698		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	9,380,917		192.00
193.00	NONPAID WORKERS	0	0		193.00
194.00	RENTAL	0	0		194.00
194.01	CHILD DEVELOPMENT CENTER	0	1,226,185		194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	0		194.02
194.03	MEDICAL BUILDING	0	0		194.03
200.00	TOTAL (SUM OF LINES 118-199)	-6,126,137	97,840,800		200.00

RECLASSIFICATIONS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-6 | Date/Time Prepared: 3/29/2012 10:16 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - ADMISSION KITS					
1.00	ADULTS & PEDIATRICS	30.00	0	5,164		1.00
2.00	NURSERY	43.00	0	5,075		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,072		3.00
	TOTALS		0	15,311		
	B - INTEREST EXP ON BONDS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,134,327		1.00
	TOTALS		0	1,134,327		
	C - CAPITAL LEASE EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	28,405		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	10,318		2.00
3.00	ANESTHESIOLOGY	53.00	0	199,344		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	474,412		4.00
5.00	CT SCAN	57.00	0	159,840		5.00
6.00	LABORATORY	60.00	0	96,690		6.00
7.00	RESPIRATORY THERAPY	65.00	0	24,174		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,233		8.00
	TOTALS		0	997,416		
	D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	86,779		1.00
	TOTALS		0	86,779		
	E - IMPLANT DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	814,711		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	814,711		
	F - CAPITAL LEASE INTEREST					
1.00	ADULTS & PEDIATRICS	30.00	0	7,676		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,788		2.00
3.00	ANESTHESIOLOGY	53.00	0	53,871		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	128,205		4.00
5.00	CT SCAN	57.00	0	43,195		5.00
6.00	LABORATORY	60.00	0	26,130		6.00
7.00	RESPIRATORY THERAPY	65.00	0	6,533		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,144		8.00
	TOTALS		0	269,542		
500.00	Grand Total: Increases		0	3,318,086		500.00

RECLASSIFICATIONS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-6 | Date/Time Prepared: 3/29/2012 10:16 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADMISSION KITS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,311	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	15,311			
	B - INTEREST EXP ON BONDS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,134,327	11		1.00
	TOTALS		0	1,134,327			
	C - CAPITAL LEASE EXPENSE						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	997,416	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	997,416			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,779	9		1.00
	TOTALS		0	86,779			
	E - IMPLANT DEVICES						
1.00	OPERATING ROOM	50.00	0	437,451	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	377,260	0		2.00
	TOTALS		0	814,711			
	F - CAPITAL LEASE INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	269,542	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	269,542			
500.00	Grand Total: Decreases		0	3,318,086			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 3/29/2012 10:16 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	2,172,770	0	0	0	0	1.00
2.00	Land Improvements	7,192,014	12,353	0	12,353	0	2.00
3.00	Buildings and Fixtures	42,940,418	0	0	0	0	3.00
4.00	Building Improvements	18,324,906	201,597	0	201,597	0	4.00
5.00	Fixed Equipment	98,327	0	0	0	0	5.00
6.00	Movable Equipment	50,161,422	365,622	0	365,622	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,889,857	579,572	0	579,572	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	120,889,857	579,572	0	579,572	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,499,776	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,195,620	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,695,396	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	70,942,385	0	70,942,385	0.621665	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	50,527,044	7,352,736	43,174,308	0.378335	0	2.00
3.00	Total (sum of lines 1-2)	121,469,429	7,352,736	114,116,693	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 3/29/2012 10:16 am

		Ending Balance	Fully Depreciated Assets		
		6.00	7.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				
1.00	Land	2,172,770	0		1.00
2.00	Land Improvements	7,204,367	0		2.00
3.00	Buildings and Fixtures	42,940,418	0		3.00
4.00	Building Improvements	18,526,503	0		4.00
5.00	Fixed Equipment	98,327	0		5.00
6.00	Movable Equipment	50,527,044	0		6.00
7.00	HIT designated Assets	0	0		7.00
8.00	Subtotal (sum of lines 1-7)	121,469,429	0		8.00
9.00	Reconciling Items	0	0		9.00
10.00	Total (line 8 minus line 9)	121,469,429	0		10.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	56,438	3,556,214		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,195,620		2.00
3.00	Total (sum of lines 1-2)	56,438	7,751,834		3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,499,776	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,284,983	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,784,759	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-7 Parts I-III Date/Time Prepared: 3/29/2012 10:16 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	NEW CAP REL COSTS-BLDG & FIXT	943,345	0	0	56,438	4,499,559	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,284,983	2.00
3.00	Total (sum of lines 1-2)	943,345	0	0	56,438	7,784,542	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-29,982	NEW CAP REL COSTS-BLDG & FIXT	1.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-33	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)	A	-8,598	OPERATION OF PLANT	7.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,916,172			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-543,867	DIETARY	10.00	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	-59,281	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	MISC INCOME	B	-12,016	ADMINISTRATIVE & GENERAL	5.00	33.00
34.00	RECRUITMENT FEES	A	-94,625	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	STAFF DEVELOPMENT	B	-7,020	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	NON ALLOWED ADVERTISING COSTS	A	-739,187	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	NURSERY PHOTOS	B	-1,362	NURSERY	43.00	37.00
38.00	ULTRAFAST LAB TEST	B	-1,504	LABORATORY	60.00	38.00
39.00	MEDICAID/FRA	A	5,707,605	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00	LOBBYING EXPENSE	A	-11,111	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00	ALCOHOLIC BEVERAGE EXPENSE	A	-1,535	ADMINISTRATIVE & GENERAL	5.00	41.00
42.00	EEG CONTRACT SERVICE	B	-13,892	ELECTROENCEPHALOGRAPHY	70.00	42.00
43.00	P/T CONTRACT SERVICE	B	-104,399	PHYSICAL THERAPY	66.00	43.00
44.00	EMPLOYED PHYSICIAN BENEFITS	A	-1,404,132	EMPLOYEE BENEFITS	4.00	44.00
45.00	DEVELOPMENT SALARIES	A	-265,130	ADMINISTRATIVE & GENERAL	5.00	45.00
45.01	DEVELOPMENT EXPENSE	A	-169,923	ADMINISTRATIVE & GENERAL	5.00	45.01
45.02	SPEECH CONTRACT SERVICE	B	-144,748	SPEECH PATHOLOGY	68.00	45.02
45.03	OTHER - MISC	B	-25,374	ADMINISTRATIVE & GENERAL	5.00	45.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
45.04	MISC REVENUE	B	-635	RADIOLOGY-DIAGNOSTIC	54.00	45.04
45.05	MISC REVENUE	B	-605	DELIVERY ROOM & LABOR ROOM	52.00	45.05
45.06	MISC REVENUE	B	-4,836	ADULTS & PEDIATRICS	30.00	45.06
45.07	BUILDING RENTAL INCOME	B	-161,000	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.07
45.08	CANCER CENTER OTHER REV	B	-15	CANCER CENTER	76.00	45.08
45.09	PLANT OPERATIONS OTHER REV	B	-3,247	OPERATION OF PLANT	7.00	45.09
45.10	CONTRIBUTIONS	A	-1,700	ADMINISTRATIVE & GENERAL	5.00	45.10
45.11	ADVERTISING EMPLOYEE BENEFITS	A	-51,650	EMPLOYEE BENEFITS	4.00	45.11
45.12	FOUNDATION EMPLOYEE BENEFITS	A	-56,163	EMPLOYEE BENEFITS	4.00	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,126,137			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Wkst. A-7 Ref.		
		5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	11		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	MISC INCOME	0		33.00
34.00	RECRUITMENT FEES	0		34.00
35.00	STAFF DEVELOPMENT	0		35.00
36.00	NON ALLOWED ADVERTISING COSTS	0		36.00
37.00	NURSERY PHOTOS	0		37.00
38.00	ULTRAFAST LAB TEST	0		38.00
39.00	MEDICAID/FRA	0		39.00
40.00	LOBBYING EXPENSE	0		40.00
41.00	ALCOHOLIC BEVERAGE EXPENSE	0		41.00
42.00	EEG CONTRACT SERVICE	0		42.00
43.00	P/T CONTRACT SERVICE	0		43.00
44.00	EMPLOYED PHYSICIAN BENEFITS	0		44.00
45.00	DEVELOPMENT SALARIES	0		45.00
45.01	DEVELOPMENT EXPENSE	0		45.01
45.02	SPEECH CONTRACT SERVICE	0		45.02
45.03	OTHER - MISC	0		45.03
45.04	MISC REVENUE	0		45.04
45.05	MISC REVENUE	0		45.05
45.06	MISC REVENUE	0		45.06
45.07	BUILDING RENTAL INCOME	11		45.07
45.08	CANCER CENTER OTHER REV	0		45.08
45.09	PLANT OPERATIONS OTHER REV	0		45.09
45.10	CONTRIBUTIONS	0		45.10
45.11	ADVERTISING EMPLOYEE BENEFITS	0		45.11
45.12	FOUNDATION EMPLOYEE BENEFITS	0		45.12

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8 | Date/Time Prepared: 3/29/2012 10:16 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/29/2012 10:16 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.00	ADMINISTRATIVE & GENERAL	487,081	366,243	1.00
2.00		15.00	PHARMACY	4,760	4,760	2.00
3.00		30.00	ADULTS & PEDIATRICS	0	0	3.00
4.00		31.00	INTENSIVE CARE UNIT	0	0	4.00
5.00		40.00	SUBPROVIDER	0	0	5.00
6.00		50.00	OPERATING ROOM	0	0	6.00
7.00		53.00	ANESTHESIOLOGY	3,084,979	3,029,455	7.00
8.00		60.00	LABORATORY	400,260	0	8.00
9.00		69.00	ELECTROCARDIOLOGY	32,969	32,969	9.00
10.00		70.00	ELECTROENCEPHALOGRAPHY	180	180	10.00
11.00		76.00	CANCER CENTER	60,460	460	11.00
12.00		91.00	EMERGENCY	3,621,679	3,428,012	12.00
13.00		91.01	OUTPATIENT PSYCH	444,074	444,074	13.00
14.00		54.00	RADIOLOGY	37	37	14.00
200.00			TOTAL (lines 1.00 through 199.00)	8,136,479	7,306,190	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/29/2012 10:16 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		120,838	159,800	1,043	80,130	4,007	1.00
2.00		0	0	0	0	0	2.00
3.00		0	159,800	0	0	0	3.00
4.00		0	159,800	0	0	0	4.00
5.00		0	138,700	0	0	0	5.00
6.00		0	182,900	0	0	0	6.00
7.00		55,524	167,500	126	10,147	507	7.00
8.00		400,260	208,000	489	48,900	2,445	8.00
9.00		0	159,800	0	0	0	9.00
10.00		0	0	0	0	0	10.00
11.00		60,000	159,800	188	14,444	722	11.00
12.00		193,667	159,800	868	66,686	3,334	12.00
13.00		0	138,700	0	0	0	13.00
14.00		0	0	0	0	0	14.00
200.00		830,289		2,714	220,307	11,015	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/29/2012 10:16 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	80,130	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	10,147	7.00
8.00		0	0	0	0	48,900	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
11.00		0	0	0	0	14,444	11.00
12.00		0	0	0	0	66,686	12.00
13.00		0	0	0	0	0	13.00
14.00		0	0	0	0	0	14.00
200.00		0	0	0	0	220,307	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 3/29/2012 10:16 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		40,708	406,951		1.00
2.00		0	4,760		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		45,377	3,074,832		7.00
8.00		351,360	351,360		8.00
9.00		0	32,969		9.00
10.00		0	180		10.00
11.00		45,556	46,016		11.00
12.00		126,981	3,554,993		12.00
13.00		0	444,074		13.00
14.00		0	37		14.00
200.00		609,982	7,916,172		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,499,559	4,499,559				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,284,983		3,284,983			2.00
4.00	EMPLOYEE BENEFITS	9,414,966	0	4,651	9,419,617		4.00
5.00	ADMINISTRATIVE & GENERAL	18,352,453	518,075	1,084,032	1,646,959	21,601,519	5.00
6.00	MAINTENANCE & REPAIRS	263,772	0	973	45,774	310,519	6.00
7.00	OPERATION OF PLANT	2,053,353	391,819	48,375	137,975	2,631,522	7.00
8.00	LAUNDRY & LINEN SERVICE	291,285	8,353	489	6,088	306,215	8.00
9.00	HOUSEKEEPING	764,772	25,423	2,998	120,566	913,759	9.00
10.00	DIETARY	982,607	97,125	12,841	165,393	1,257,966	10.00
11.00	CAFETERIA	0	80,418	0	0	80,418	11.00
13.00	NURSING ADMINISTRATION	561,569	16,110	18,248	103,699	699,626	13.00
14.00	CENTRAL SERVICES & SUPPLY	258,734	62,259	3,420	26,196	350,609	14.00
15.00	PHARMACY	2,218,689	55,203	137,097	337,117	2,748,106	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,029,080	35,280	12,932	140,740	1,218,032	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,061,208	930,933	49,260	1,094,223	8,135,624	30.00
31.00	INTENSIVE CARE UNIT	2,224,994	141,536	40,161	361,837	2,768,528	31.00
40.00	SUBPROVIDER - IPF	880,206	169,060	5,014	164,003	1,218,283	40.00
43.00	NURSERY	365,806	0	4,430	52,606	422,842	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,146,346	186,908	218,314	197,639	1,749,207	50.00
51.00	RECOVERY ROOM	865,278	189,683	1,180	160,516	1,216,657	51.00
52.00	DELIVERY ROOM & LABOR ROOM	897,124	0	8,915	160,778	1,066,817	52.00
53.00	ANESTHESIOLOGY	601,196	3,113	2,502	23,185	629,996	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,367,301	267,326	201,256	254,140	3,090,023	54.00
56.00	RADIOISOTOPE	182,476	9,961	953	20,594	213,984	56.00
57.00	CT SCAN	653,486	20,131	13,180	56,439	743,236	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	185,234	15,435	81,275	13,310	295,254	58.00
60.00	LABORATORY	3,268,623	139,124	79,048	268,148	3,754,943	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	812,234	2,594	2,466	22,313	839,607	62.00
65.00	RESPIRATORY THERAPY	989,953	30,611	15,029	159,981	1,195,574	65.00
66.00	PHYSICAL THERAPY	1,830,540	99,719	15,502	328,928	2,274,689	66.00
68.00	SPEECH PATHOLOGY	119,421	0	994	47,880	168,295	68.00
69.00	ELECTROCARDIOLOGY	1,674,654	238,972	256,705	223,767	2,394,098	69.00
70.00	ELECTROENCEPHALOGRAPHY	158,534	5,188	10,897	30,769	205,388	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,649,703	0	0	0	6,649,703	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	814,711	0	0	0	814,711	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,802,109	0	0	0	2,802,109	73.00
76.00	CANCER CENTER	1,248,896	0	192,821	137,559	1,579,276	76.00
76.01	DIABETES CENTER	56,532	0	1,287	9,809	67,628	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	736,271	0	1,758	118,743	856,772	88.00
88.01	RURAL HEALTH CLINIC II	516,887	0	414	90,206	607,507	88.01
88.02	RURAL HEALTH CLINIC III	705,414	0	12,494	112,399	830,307	88.02
91.00	EMERGENCY	2,644,967	724,439	400,878	465,654	4,235,938	91.00
91.01	OUTPATIENT PSYCH	692,802	0	7,881	118,584	819,267	91.01
91.02	WOUND CARE	23,231	0	0	4,089	27,320	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,081,739	0	15,873	176,704	1,274,316	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)	87,233,698	4,464,798	2,966,543	7,605,310	85,066,190	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	9,380,917	2,075	312,661	1,625,607	11,321,260	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	1,226,185	0	5,779	188,700	1,420,664	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	32,686	0	0	32,686	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	97,840,800	4,499,559	3,284,983	9,419,617	97,840,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 3/29/2012 10:16 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	21,601,519					5.00
6.00	MAINTENANCE & REPAIRS	87,982	398,501				6.00
7.00	OPERATION OF PLANT	745,610	36,892	3,414,024			7.00
8.00	LAUNDRY & LINEN SERVICE	86,762	493	4,653	398,123		8.00
9.00	HOUSEKEEPING	258,903	1,500	14,161	0	1,188,323	9.00
10.00	DIETARY	356,430	5,730	54,100	0	32,458	10.00
11.00	CAFETERIA	22,785	4,745	44,795	0	26,875	11.00
13.00	NURSING ADMINISTRATION	198,231	950	8,973	0	5,384	13.00
14.00	CENTRAL SERVICES & SUPPLY	99,341	3,673	34,680	0	20,806	14.00
15.00	PHARMACY	778,643	3,257	30,749	0	18,448	15.00
16.00	MEDICAL RECORDS & LIBRARY	345,115	2,082	19,652	0	11,790	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,305,131	54,924	518,550	173,724	311,103	30.00
31.00	INTENSIVE CARE UNIT	784,429	8,351	78,839	25,214	47,299	31.00
40.00	SUBPROVIDER - IPF	345,186	9,974	94,170	7,157	56,497	40.00
43.00	NURSERY	119,807	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	495,617	11,027	104,112	49,043	62,462	50.00
51.00	RECOVERY ROOM	344,725	11,191	105,658	25,822	63,389	51.00
52.00	DELIVERY ROOM & LABOR ROOM	302,270	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	178,502	184	1,734	0	1,040	53.00
54.00	RADIOLOGY-DIAGNOSTIC	875,521	17,815	168,197	24,780	89,336	54.00
56.00	RADIOISOTOPE	60,630	588	5,549	0	3,329	56.00
57.00	CT SCAN	210,587	1,188	11,213	0	6,727	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	83,657	911	8,598	0	5,158	58.00
60.00	LABORATORY	1,063,918	10,157	95,890	26	46,493	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	237,893	153	1,445	0	867	62.00
65.00	RESPIRATORY THERAPY	338,752	3,814	36,009	0	10,230	65.00
66.00	PHYSICAL THERAPY	644,506	5,883	55,545	3,379	33,324	66.00
68.00	SPEECH PATHOLOGY	47,684	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	678,339	14,099	133,113	14,312	79,861	69.00
70.00	ELECTROENCEPHALOGRAPHY	58,194	306	2,890	875	1,734	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,884,114	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	230,839	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	793,944	0	0	0	0	73.00
76.00	CANCER CENTER	447,469	27,243	257,209	4,997	0	76.00
76.01	DIABETES CENTER	19,162	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	242,756	4,898	46,240	217	0	88.00
88.01	RURAL HEALTH CLINIC II	172,130	5,491	51,846	0	0	88.01
88.02	RURAL HEALTH CLINIC III	235,258	10,331	97,537	1,008	0	88.02
91.00	EMERGENCY	1,200,202	42,741	403,528	63,336	242,096	91.00
91.01	OUTPATIENT PSYCH	232,129	0	0	0	0	91.01
91.02	WOUND CARE	7,741	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	361,062	5,586	52,742	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)	17,981,956	306,177	2,542,377	393,890	1,176,706	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,207,774	56,980	537,955	4,233	694	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	402,528	33,416	315,485	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	9,261	1,928	18,207	0	10,923	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	21,601,519	398,501	3,414,024	398,123	1,188,323	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW 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	1,706,684					10.00
11.00	CAFETERIA	1,140,918	1,320,536				11.00
13.00	NURSING ADMINISTRATION	0	19,370	932,534			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	8,324	0	517,433		14.00
15.00	PHARMACY	0	54,074	0	0	3,633,277	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	42,360	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	448,929	259,164	368,248	0	0	30.00
31.00	INTENSIVE CARE UNIT	58,555	73,375	104,251	0	0	31.00
40.00	SUBPROVIDER - IPF	58,282	28,847	41,007	0	0	40.00
43.00	NURSERY	0	12,752	18,105	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	43,029	61,150	0	0	50.00
51.00	RECOVERY ROOM	0	31,753	45,117	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	28,086	39,909	0	0	52.00
53.00	ANESTHESIOLOGY	0	17,271	3,187	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	49,162	0	0	0	54.00
56.00	RADIOISOTOPE	0	2,952	0	0	0	56.00
57.00	CT SCAN	0	10,700	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	2,675	0	0	0	58.00
60.00	LABORATORY	0	78,724	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,497	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	35,073	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	62,790	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	9,454	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	41,138	25,933	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	6,318	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	517,433	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,633,277	73.00
76.00	CANCER CENTER	0	15,242	0	0	0	76.00
76.01	DIABETES CENTER	0	1,937	2,752	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	116,057	138,440	0	0	91.00
91.01	OUTPATIENT PSYCH	0	29,562	0	0	0	91.01
91.02	WOUND CARE	0	784	1,106	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	83,329	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)	1,706,684	1,085,470	932,534	517,433	3,633,277	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	157,172	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	0	77,894	0	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	0	0	0	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,706,684	1,320,536	932,534	517,433	3,633,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part I Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW 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
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	1,639,031					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,001,974	13,577,371	0	13,577,371		30.00
31.00	INTENSIVE CARE UNIT	216,921	4,165,762	0	4,165,762		31.00
40.00	SUBPROVIDER - IPF	86,056	1,945,459	0	1,945,459		40.00
43.00	NURSERY	84,160	657,666	0	657,666		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	2,575,647	0	2,575,647		50.00
51.00	RECOVERY ROOM	0	1,844,312	0	1,844,312		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,437,082	0	1,437,082		52.00
53.00	ANESTHESIOLOGY	0	831,914	0	831,914		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,314,834	0	4,314,834		54.00
56.00	RADIOISOTOPE	0	287,032	0	287,032		56.00
57.00	CT SCAN	0	983,651	0	983,651		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	396,253	0	396,253		58.00
60.00	LABORATORY	0	5,050,151	0	5,050,151		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,084,462	0	1,084,462		62.00
65.00	RESPIRATORY THERAPY	0	1,619,452	0	1,619,452		65.00
66.00	PHYSICAL THERAPY	0	3,080,116	0	3,080,116		66.00
68.00	SPEECH PATHOLOGY	0	225,433	0	225,433		68.00
69.00	ELECTROCARDIOLOGY	0	3,380,893	0	3,380,893		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	275,705	0	275,705		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,051,250	0	9,051,250		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,045,550	0	1,045,550		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,229,330	0	7,229,330		73.00
76.00	CANCER CENTER	0	2,331,436	0	2,331,436		76.00
76.01	DIABETES CENTER	0	91,479	0	91,479		76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,150,883	0	1,150,883		88.00
88.01	RURAL HEALTH CLINIC II	0	836,974	0	836,974		88.01
88.02	RURAL HEALTH CLINIC III	0	1,174,441	0	1,174,441		88.02
91.00	EMERGENCY	249,920	6,692,258	0	6,692,258		91.00
91.01	OUTPATIENT PSYCH	0	1,080,958	0	1,080,958		91.01
91.02	WOUND CARE	0	36,951	0	36,951		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	FAMILY PRACTICE	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,777,035	0	1,777,035		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,639,031	80,231,740	0	80,231,740		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	15,286,068	0	15,286,068		192.00
193.00	NONPAID WORKERS	0	0	0	0		193.00
194.00	RENTAL	0	0	0	0		194.00
194.01	CHILD DEVELOPMENT CENTER	0	2,249,987	0	2,249,987		194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	73,005	0	73,005		194.02
194.03	MEDICAL BUILDING	0	0	0	0		194.03
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	1,639,031	97,840,800	0	97,840,800		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	1,140	0	4,651	5,791	5,791	4.00
5.00	ADMINISTRATIVE & GENERAL	48,818	518,075	1,084,032	1,650,925	1,000	5.00
6.00	MAINTENANCE & REPAIRS	1,854	0	973	2,827	28	6.00
7.00	OPERATION OF PLANT	6,839	391,819	48,375	447,033	85	7.00
8.00	LAUNDRY & LINEN SERVICE	3,106	8,353	489	11,948	4	8.00
9.00	HOUSEKEEPING	6,799	25,423	2,998	35,220	74	9.00
10.00	DIETARY	1,788	97,125	12,841	111,754	102	10.00
11.00	CAFETERIA	0	80,418	0	80,418	0	11.00
13.00	NURSING ADMINISTRATION	746	16,110	18,248	35,104	64	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	62,259	3,420	65,679	16	14.00
15.00	PHARMACY	1,830	55,203	137,097	194,130	208	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,832	35,280	12,932	53,044	87	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	27,902	930,933	49,260	1,008,095	674	30.00
31.00	INTENSIVE CARE UNIT	17,244	141,536	40,161	198,941	223	31.00
40.00	SUBPROVIDER - IPF	1,028	169,060	5,014	175,102	101	40.00
43.00	NURSERY	1,740	0	4,430	6,170	32	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	111,678	186,908	218,314	516,900	122	50.00
51.00	RECOVERY ROOM	431	189,683	1,180	191,294	99	51.00
52.00	DELIVERY ROOM & LABOR ROOM	720	0	8,915	9,635	99	52.00
53.00	ANESTHESIOLOGY	2,316	3,113	2,502	7,931	14	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,906	267,326	201,256	472,488	157	54.00
56.00	RADIOISOTOPE	87	9,961	953	11,001	13	56.00
57.00	CT SCAN	912	20,131	13,180	34,223	35	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	69	15,435	81,275	96,779	8	58.00
60.00	LABORATORY	2,759	139,124	79,048	220,931	165	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	370	2,594	2,466	5,430	14	62.00
65.00	RESPIRATORY THERAPY	26,324	30,611	15,029	71,964	99	65.00
66.00	PHYSICAL THERAPY	102,088	99,719	15,502	217,309	203	66.00
68.00	SPEECH PATHOLOGY	463	0	994	1,457	29	68.00
69.00	ELECTROCARDIOLOGY	3,895	238,972	256,705	499,572	138	69.00
70.00	ELECTROENCEPHALOGRAPHY	568	5,188	10,897	16,653	19	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CANCER CENTER	1,762	0	192,821	194,583	85	76.00
76.01	DIABETES CENTER	69	0	1,287	1,356	6	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	17,011	0	1,758	18,769	73	88.00
88.01	RURAL HEALTH CLINIC II	440	0	414	854	56	88.01
88.02	RURAL HEALTH CLINIC III	2,917	0	12,494	15,411	69	88.02
91.00	EMERGENCY	3,420	724,439	400,878	1,128,737	287	91.00
91.01	OUTPATIENT PSYCH	2,967	0	7,881	10,848	73	91.01
91.02	WOUND CARE	0	0	0	0	3	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	3,131	0	15,873	19,004	109	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)	413,969	4,464,798	2,966,543	7,845,310	4,673	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	70,889	2,075	312,661	385,625	1,002	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	4,721	0	5,779	10,500	116	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	32,686	0	32,686	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	489,579	4,499,559	3,284,983	8,274,121	5,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 3/29/2012 10:16 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	1,651,925					5.00
6.00	MAINTENANCE & REPAIRS	6,728	9,583				6.00
7.00	OPERATION OF PLANT	57,020	887	505,025			7.00
8.00	LAUNDRY & LINEN SERVICE	6,635	12	688	19,287		8.00
9.00	HOUSEKEEPING	19,799	36	2,095	0	57,224	9.00
10.00	DIETARY	27,258	138	8,003	0	1,563	10.00
11.00	CAFETERIA	1,742	114	6,626	0	1,294	11.00
13.00	NURSING ADMINISTRATION	15,159	23	1,327	0	259	13.00
14.00	CENTRAL SERVICES & SUPPLY	7,597	88	5,130	0	1,002	14.00
15.00	PHARMACY	59,546	78	4,549	0	888	15.00
16.00	MEDICAL RECORDS & LIBRARY	26,392	50	2,907	0	568	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	176,283	1,321	76,707	8,418	14,981	30.00
31.00	INTENSIVE CARE UNIT	59,988	201	11,662	1,221	2,278	31.00
40.00	SUBPROVIDER - IPF	26,398	240	13,930	347	2,721	40.00
43.00	NURSERY	9,162	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	37,902	265	15,401	2,376	3,008	50.00
51.00	RECOVERY ROOM	26,363	269	15,630	1,251	3,053	51.00
52.00	DELIVERY ROOM & LABOR ROOM	23,116	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	13,651	4	257	0	50	53.00
54.00	RADIOLOGY-DIAGNOSTIC	66,955	428	24,881	1,200	4,302	54.00
56.00	RADIOISOTOPE	4,637	14	821	0	160	56.00
57.00	CT SCAN	16,104	29	1,659	0	324	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	6,398	22	1,272	0	248	58.00
60.00	LABORATORY	81,362	244	14,185	1	2,239	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	18,193	4	214	0	42	62.00
65.00	RESPIRATORY THERAPY	25,906	92	5,327	0	493	65.00
66.00	PHYSICAL THERAPY	49,288	141	8,217	164	1,605	66.00
68.00	SPEECH PATHOLOGY	3,647	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	51,875	339	19,691	693	3,846	69.00
70.00	ELECTROENCEPHALOGRAPHY	4,450	7	428	42	83	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,086	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	17,653	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	60,716	0	0	0	0	73.00
76.00	CANCER CENTER	34,220	655	38,048	242	0	76.00
76.01	DIABETES CENTER	1,465	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	18,565	118	6,840	10	0	88.00
88.01	RURAL HEALTH CLINIC II	13,163	132	7,669	0	0	88.01
88.02	RURAL HEALTH CLINIC III	17,991	248	14,428	49	0	88.02
91.00	EMERGENCY	91,784	1,028	59,693	3,068	11,658	91.00
91.01	OUTPATIENT PSYCH	17,752	0	0	0	0	91.01
91.02	WOUND CARE	592	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	27,612	134	7,802	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)	1,375,153	7,361	376,087	19,082	56,665	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	245,281	1,372	79,576	205	33	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	30,783	804	46,669	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	708	46	2,693	0	526	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,651,925	9,583	505,025	19,287	57,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW 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	148,818					10.00
11.00	CAFETERIA	99,485	189,679				11.00
13.00	NURSING ADMINISTRATION	0	2,782	54,718			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,196	0	80,708		14.00
15.00	PHARMACY	0	7,767	0	0	267,166	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	6,084	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	39,145	37,224	21,609	0	0	30.00
31.00	INTENSIVE CARE UNIT	5,106	10,539	6,117	0	0	31.00
40.00	SUBPROVIDER - IPF	5,082	4,144	2,406	0	0	40.00
43.00	NURSERY	0	1,832	1,062	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	6,181	3,588	0	0	50.00
51.00	RECOVERY ROOM	0	4,561	2,647	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	4,034	2,342	0	0	52.00
53.00	ANESTHESIOLOGY	0	2,481	187	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,062	0	0	0	54.00
56.00	RADIOISOTOPE	0	424	0	0	0	56.00
57.00	CT SCAN	0	1,537	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	384	0	0	0	58.00
60.00	LABORATORY	0	11,308	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	646	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	5,038	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	9,019	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	1,358	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,909	1,522	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	908	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,708	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	267,166	73.00
76.00	CANCER CENTER	0	2,189	0	0	0	76.00
76.01	DIABETES CENTER	0	278	161	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	16,670	8,123	0	0	91.00
91.01	OUTPATIENT PSYCH	0	4,246	0	0	0	91.01
91.02	WOUND CARE	0	113	65	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	4,889	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)	148,818	155,914	54,718	80,708	267,166	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	22,576	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	0	11,189	0	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	0	0	0	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	148,818	189,679	54,718	80,708	267,166	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B Part II | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW 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
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	89,132					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	54,488	1,438,945	0	1,438,945		30.00
31.00	INTENSIVE CARE UNIT	11,796	308,072	0	308,072		31.00
40.00	SUBPROVIDER - IPF	4,680	235,151	0	235,151		40.00
43.00	NURSERY	4,577	22,835	0	22,835		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	585,743	0	585,743		50.00
51.00	RECOVERY ROOM	0	245,167	0	245,167		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	39,226	0	39,226		52.00
53.00	ANESTHESIOLOGY	0	24,575	0	24,575		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	577,473	0	577,473		54.00
56.00	RADIOISOTOPE	0	17,070	0	17,070		56.00
57.00	CT SCAN	0	53,911	0	53,911		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	105,111	0	105,111		58.00
60.00	LABORATORY	0	330,435	0	330,435		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	24,543	0	24,543		62.00
65.00	RESPIRATORY THERAPY	0	108,919	0	108,919		65.00
66.00	PHYSICAL THERAPY	0	285,946	0	285,946		66.00
68.00	SPEECH PATHOLOGY	0	6,491	0	6,491		68.00
69.00	ELECTROCARDIOLOGY	0	583,585	0	583,585		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	22,590	0	22,590		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	224,794	0	224,794		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	17,653	0	17,653		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	327,882	0	327,882		73.00
76.00	CANCER CENTER	0	270,022	0	270,022		76.00
76.01	DIABETES CENTER	0	3,266	0	3,266		76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	44,375	0	44,375		88.00
88.01	RURAL HEALTH CLINIC II	0	21,874	0	21,874		88.01
88.02	RURAL HEALTH CLINIC III	0	48,196	0	48,196		88.02
91.00	EMERGENCY	13,591	1,334,639	0	1,334,639		91.00
91.01	OUTPATIENT PSYCH	0	32,919	0	32,919		91.01
91.02	WOUND CARE	0	773	0	773		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	FAMILY PRACTICE	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	59,550	0	59,550		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	89,132	7,401,731	0	7,401,731		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	735,670	0	735,670		192.00
193.00	NONPAID WORKERS	0	0	0	0		193.00
194.00	RENTAL	0	0	0	0		194.00
194.01	CHILD DEVELOPMENT CENTER	0	100,061	0	100,061		194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	36,659	0	36,659		194.02
194.03	MEDICAL BUILDING	0	0	0	0		194.03
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	89,132	8,274,121	0	8,274,121		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	173,451					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		3,028,614				2.00
4.00	EMPLOYEE BENEFITS	0	4,288	43,310,743			4.00
5.00	ADMINISTRATIVE & GENERAL	19,971	999,429	7,572,594	-21,601,519	76,239,281	5.00
6.00	MAINTENANCE & REPAIRS	0	897	210,464	0	310,519	6.00
7.00	OPERATION OF PLANT	15,104	44,600	634,401	0	2,631,522	7.00
8.00	LAUNDRY & LINEN SERVICE	322	451	27,993	0	306,215	8.00
9.00	HOUSEKEEPING	980	2,764	554,356	0	913,759	9.00
10.00	DIETARY	3,744	11,839	760,465	0	1,257,966	10.00
11.00	CAFETERIA	3,100	0	0	0	80,418	11.00
13.00	NURSING ADMINISTRATION	621	16,824	476,800	0	699,626	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,400	3,153	120,446	0	350,609	14.00
15.00	PHARMACY	2,128	126,398	1,550,040	0	2,748,106	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,360	11,923	647,114	0	1,218,032	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	35,886	45,416	5,031,165	0	8,135,624	30.00
31.00	INTENSIVE CARE UNIT	5,456	37,027	1,663,702	0	2,768,528	31.00
40.00	SUBPROVIDER - IPF	6,517	4,623	754,076	0	1,218,283	40.00
43.00	NURSERY	0	4,084	241,877	0	422,842	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,205	201,276	908,729	0	1,749,207	50.00
51.00	RECOVERY ROOM	7,312	1,088	738,040	0	1,216,657	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	8,219	739,246	0	1,066,817	52.00
53.00	ANESTHESIOLOGY	120	2,307	106,603	0	629,996	53.00
54.00	RADIOLOGY-DIAGNOSTIC	10,305	185,549	1,168,518	0	3,090,023	54.00
56.00	RADIOISOTOPE	384	879	94,689	0	213,984	56.00
57.00	CT SCAN	776	12,151	259,501	0	743,236	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	595	74,932	61,199	0	295,254	58.00
60.00	LABORATORY	5,363	72,879	1,232,927	0	3,754,943	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	100	2,274	102,594	0	839,607	62.00
65.00	RESPIRATORY THERAPY	1,180	13,856	735,580	0	1,195,574	65.00
66.00	PHYSICAL THERAPY	3,844	14,292	1,512,387	0	2,274,689	66.00
68.00	SPEECH PATHOLOGY	0	916	220,147	0	168,295	68.00
69.00	ELECTROCARDIOLOGY	9,212	236,671	1,028,867	0	2,394,098	69.00
70.00	ELECTROENCEPHALOGRAPHY	200	10,047	141,475	0	205,388	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,649,703	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	814,711	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,802,109	73.00
76.00	CANCER CENTER	0	177,773	632,489	0	1,579,276	76.00
76.01	DIABETES CENTER	0	1,187	45,103	0	67,628	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,621	545,974	0	856,772	88.00
88.01	RURAL HEALTH CLINIC II	0	382	414,762	0	607,507	88.01
88.02	RURAL HEALTH CLINIC III	0	11,519	516,801	0	830,307	88.02
91.00	EMERGENCY	27,926	369,592	2,141,045	0	4,235,938	91.00
91.01	OUTPATIENT PSYCH	0	7,266	545,240	0	819,267	91.01
91.02	WOUND CARE	0	0	18,801	0	27,320	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	14,634	812,473	0	1,274,316	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)	172,111	2,735,026	34,968,683	-21,601,519	63,464,671	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	80	288,260	7,474,431	0	11,321,260	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	0	5,328	867,629	0	1,420,664	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	1,260	0	0	0	32,686	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,499,559	3,284,983	9,419,617		21,601,519	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25.941384	1.084649	0.217489		0.283338	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			5,791		1,651,925	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000134		0.021668	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	MAINTENANCE & REPAIRS (DOLLAR VALUE)	OPERATION OF PLANT (DOLLAR VALUE)	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	260,370					6.00
7.00	OPERATION OF PLANT	24,104	236,266				7.00
8.00	LAUNDRY & LINEN SERVICE	322	322	495,995			8.00
9.00	HOUSEKEEPING	980	980	0	137,074		9.00
10.00	DIETARY	3,744	3,744	0	3,744	256,347	10.00
11.00	CAFETERIA	3,100	3,100	0	3,100	171,368	11.00
13.00	NURSING ADMINISTRATION	621	621	0	621	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,400	2,400	0	2,400	0	14.00
15.00	PHARMACY	2,128	2,128	0	2,128	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,360	1,360	0	1,360	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	35,886	35,886	216,428	35,886	67,430	30.00
31.00	INTENSIVE CARE UNIT	5,456	5,456	31,413	5,456	8,795	31.00
40.00	SUBPROVIDER - IPF	6,517	6,517	8,916	6,517	8,754	40.00
43.00	NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,205	7,205	61,100	7,205	0	50.00
51.00	RECOVERY ROOM	7,312	7,312	32,170	7,312	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	11,640	11,640	30,872	10,305	0	54.00
56.00	RADIOISOTOPE	384	384	0	384	0	56.00
57.00	CT SCAN	776	776	0	776	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	595	595	0	595	0	58.00
60.00	LABORATORY	6,636	6,636	33	5,363	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	100	100	0	100	0	62.00
65.00	RESPIRATORY THERAPY	2,492	2,492	0	1,180	0	65.00
66.00	PHYSICAL THERAPY	3,844	3,844	4,210	3,844	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	9,212	9,212	17,831	9,212	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	200	200	1,090	200	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CANCER CENTER	17,800	17,800	6,226	0	0	76.00
76.01	DIABETES CENTER	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	3,200	3,200	270	0	0	88.00
88.01	RURAL HEALTH CLINIC II	3,588	3,588	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	6,750	6,750	1,256	0	0	88.02
91.00	EMERGENCY	27,926	27,926	78,906	27,926	0	91.00
91.01	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	WOUND CARE	0	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	3,650	3,650	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)	200,048	175,944	490,721	135,734	256,347	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	37,229	37,229	5,274	80	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	21,833	21,833	0	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	1,260	1,260	0	1,260	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	398,501	3,414,024	398,123	1,188,323	1,706,684	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.530518	14.449917	0.802675	8.669208	6.657710	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	9,583	505,025	19,287	57,224	148,818	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.036805	2.137527	0.038885	0.417468	0.580533	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet B-1 | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW 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	57,267					11.00
13.00	NURSING ADMINISTRATION	840	591,969				13.00
14.00	CENTRAL SERVICES & SUPPLY	361	0	100			14.00
15.00	PHARMACY	2,345	0	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,837	0	0	0	49,272	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,239	233,763	0	0	30,121	30.00
31.00	INTENSIVE CARE UNIT	3,182	66,178	0	0	6,521	31.00
40.00	SUBPROVIDER - IPF	1,251	26,031	0	0	2,587	40.00
43.00	NURSERY	553	11,493	0	0	2,530	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,866	38,818	0	0	0	50.00
51.00	RECOVERY ROOM	1,377	28,640	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,218	25,334	0	0	0	52.00
53.00	ANESTHESIOLOGY	749	2,023	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,132	0	0	0	0	54.00
56.00	RADIOISOTOPE	128	0	0	0	0	56.00
57.00	CT SCAN	464	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	116	0	0	0	0	58.00
60.00	LABORATORY	3,414	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	195	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	1,521	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	2,723	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	410	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	1,784	16,462	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	274	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	CANCER CENTER	661	0	0	0	0	76.00
76.01	DIABETES CENTER	84	1,747	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	5,033	87,881	0	0	7,513	91.00
91.01	OUTPATIENT PSYCH	1,282	0	0	0	0	91.01
91.02	WOUND CARE	34	702	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	52,897	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)	47,073	591,969	100	100	49,272	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	6,816	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	RENTAL	0	0	0	0	0	194.00
194.01	CHILD DEVELOPMENT CENTER	3,378	0	0	0	0	194.01
194.02	OTHER NONREIMBURSEABLE COST CENTERS	0	0	0	0	0	194.02
194.03	MEDICAL BUILDING	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,320,536	932,534	517,433	3,633,277	1,639,031	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	23.059284	1.575309	5,174.330000	36,332.770000	33.264958	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	189,679	54,718	80,708	267,166	89,132	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.312187	0.092434	807.080000	2,671.660000	1.808979	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	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	13,577,371		13,577,371	0	13,577,371	30.00
31.00	INTENSIVE CARE UNIT	4,165,762		4,165,762	0	4,165,762	31.00
40.00	SUBPROVIDER - IPF	1,945,459		1,945,459	0	1,945,459	40.00
43.00	NURSERY	657,666		657,666	0	657,666	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,575,647		2,575,647	0	2,575,647	50.00
51.00	RECOVERY ROOM	1,844,312		1,844,312	0	1,844,312	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,437,082		1,437,082	0	1,437,082	52.00
53.00	ANESTHESIOLOGY	831,914		831,914	45,377	877,291	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,314,834		4,314,834	0	4,314,834	54.00
56.00	RADIOISOTOPE	287,032		287,032	0	287,032	56.00
57.00	CT SCAN	983,651		983,651	0	983,651	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	396,253		396,253	0	396,253	58.00
60.00	LABORATORY	5,050,151		5,050,151	351,360	5,401,511	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,084,462		1,084,462	0	1,084,462	62.00
65.00	RESPIRATORY THERAPY	1,619,452	0	1,619,452	0	1,619,452	65.00
66.00	PHYSICAL THERAPY	3,080,116	0	3,080,116	0	3,080,116	66.00
68.00	SPEECH PATHOLOGY	225,433	0	225,433	0	225,433	68.00
69.00	ELECTROCARDIOLOGY	3,380,893		3,380,893	0	3,380,893	69.00
70.00	ELECTROENCEPHALOGRAPHY	275,705		275,705	0	275,705	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,051,250		9,051,250	0	9,051,250	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,045,550		1,045,550	0	1,045,550	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,229,330		7,229,330	0	7,229,330	73.00
76.00	CANCER CENTER	2,331,436		2,331,436	45,556	2,376,992	76.00
76.01	DIABETES CENTER	91,479		91,479	0	91,479	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,150,883		1,150,883	0	1,150,883	88.00
88.01	RURAL HEALTH CLINIC II	836,974		836,974	0	836,974	88.01
88.02	RURAL HEALTH CLINIC III	1,174,441		1,174,441	0	1,174,441	88.02
91.00	EMERGENCY	6,692,258		6,692,258	126,981	6,819,239	91.00
91.01	OUTPATIENT PSYCH	1,080,958		1,080,958	0	1,080,958	91.01
91.02	WOUND CARE	36,951		36,951	0	36,951	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	293,588		293,588		293,588	92.00
93.00	FAMILY PRACTICE	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,777,035		1,777,035		1,777,035	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	80,525,328	0	80,525,328	569,274	81,094,602	200.00
201.00	Less Observation Beds	293,588		293,588		293,588	201.00
202.00	Total (see instructions)	80,231,740	0	80,231,740	569,274	80,801,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	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	6,820,239		6,820,239			30.00
31.00	INTENSIVE CARE UNIT	1,794,713		1,794,713			31.00
40.00	SUBPROVIDER - IPF	1,281,086		1,281,086			40.00
43.00	NURSERY	432,137		432,137			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,989,051	5,515,940	13,504,991	0.190718	0.000000	50.00
51.00	RECOVERY ROOM	1,257,484	1,575,686	2,833,170	0.650971	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	713,021	164,181	877,202	1.638257	0.000000	52.00
53.00	ANESTHESIOLOGY	1,909,392	1,252,748	3,162,140	0.263086	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,104,035	4,071,513	6,175,548	0.698697	0.000000	54.00
56.00	RADIOISOTOPE	844,168	1,440,911	2,285,079	0.125611	0.000000	56.00
57.00	CT SCAN	4,660,384	10,143,643	14,804,027	0.066445	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	932,391	2,721,500	3,653,891	0.108447	0.000000	58.00
60.00	LABORATORY	14,202,010	16,097,315	30,299,325	0.166675	0.000000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	893,749	531,733	1,425,482	0.760769	0.000000	62.00
65.00	RESPIRATORY THERAPY	1,126,041	168,987	1,295,028	1.250515	0.000000	65.00
66.00	PHYSICAL THERAPY	991,829	2,752,083	3,743,912	0.822700	0.000000	66.00
68.00	SPEECH PATHOLOGY	69,767	245,781	315,548	0.714417	0.000000	68.00
69.00	ELECTROCARDIOLOGY	9,596,667	9,935,197	19,531,864	0.173096	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	31,655	696,315	727,970	0.378731	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,125,433	21,363,299	62,488,732	0.144846	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	577,151	1,783,521	2,360,672	0.442904	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	26,913,643	11,100,448	38,014,091	0.190175	0.000000	73.00
76.00	CANCER CENTER	113,914	5,373,933	5,487,847	0.424836	0.000000	76.00
76.01	DIABETES CENTER	0	22,066	22,066	4.145699	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	837,127	837,127			88.00
88.01	RURAL HEALTH CLINIC II	0	587,033	587,033			88.01
88.02	RURAL HEALTH CLINIC III	0	1,136,251	1,136,251			88.02
91.00	EMERGENCY	866,907	2,068,058	2,934,965	2.280183	0.000000	91.00
91.01	OUTPATIENT PSYCH	0	269,542	269,542	4.010351	0.000000	91.01
91.02	WOUND CARE	203	43,652	43,855	0.842572	0.000000	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,038	206,138	208,176	1.410287	0.000000	92.00
93.00	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,124,808	1,124,808			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	127,249,108	103,229,409	230,478,517			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	127,249,108	103,229,409	230,478,517			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
40.00	SUBPROVIDER - IPF		40.00
43.00	NURSERY		43.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.190718	50.00
51.00	RECOVERY ROOM	0.650971	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.638257	52.00
53.00	ANESTHESIOLOGY	0.277436	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.698697	54.00
56.00	RADIOISOTOPE	0.125611	56.00
57.00	CT SCAN	0.066445	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.108447	58.00
60.00	LABORATORY	0.178272	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.760769	62.00
65.00	RESPIRATORY THERAPY	1.250515	65.00
66.00	PHYSICAL THERAPY	0.822700	66.00
68.00	SPEECH PATHOLOGY	0.714417	68.00
69.00	ELECTROCARDIOLOGY	0.173096	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.378731	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144846	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.442904	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190175	73.00
76.00	CANCER CENTER	0.433137	76.00
76.01	DIABETES CENTER	4.145699	76.01
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC		88.00
88.01	RURAL HEALTH CLINIC II		88.01
88.02	RURAL HEALTH CLINIC III		88.02
91.00	EMERGENCY	2.323448	91.00
91.01	OUTPATIENT PSYCH	4.010351	91.01
91.02	WOUND CARE	0.842572	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.410287	92.00
93.00	FAMILY PRACTICE	0.000000	93.00
	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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	13,577,371		13,577,371	0	0	30.00
31.00	INTENSIVE CARE UNIT	4,165,762		4,165,762	0	0	31.00
40.00	SUBPROVIDER - IPF	1,945,459		1,945,459	0	0	40.00
43.00	NURSERY	657,666		657,666	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,575,647		2,575,647	0	0	50.00
51.00	RECOVERY ROOM	1,844,312		1,844,312	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,437,082		1,437,082	0	0	52.00
53.00	ANESTHESIOLOGY	831,914		831,914	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,314,834		4,314,834	0	0	54.00
56.00	RADIOISOTOPE	287,032		287,032	0	0	56.00
57.00	CT SCAN	983,651		983,651	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	396,253		396,253	0	0	58.00
60.00	LABORATORY	5,050,151		5,050,151	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,084,462		1,084,462	0	0	62.00
65.00	RESPIRATORY THERAPY	1,619,452	0	1,619,452	0	0	65.00
66.00	PHYSICAL THERAPY	3,080,116	0	3,080,116	0	0	66.00
68.00	SPEECH PATHOLOGY	225,433	0	225,433	0	0	68.00
69.00	ELECTROCARDIOLOGY	3,380,893		3,380,893	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	275,705		275,705	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,051,250		9,051,250	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,045,550		1,045,550	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,229,330		7,229,330	0	0	73.00
76.00	CANCER CENTER	2,331,436		2,331,436	0	0	76.00
76.01	DIABETES CENTER	91,479		91,479	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,150,883		1,150,883	0	0	88.00
88.01	RURAL HEALTH CLINIC II	836,974		836,974	0	0	88.01
88.02	RURAL HEALTH CLINIC III	1,174,441		1,174,441	0	0	88.02
91.00	EMERGENCY	6,692,258		6,692,258	0	0	91.00
91.01	OUTPATIENT PSYCH	1,080,958		1,080,958	0	0	91.01
91.02	WOUND CARE	36,951		36,951	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	293,588		293,588		0	92.00
93.00	FAMILY PRACTICE	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,777,035		1,777,035		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	80,525,328	0	80,525,328	0	0	200.00
201.00	Less Observation Beds	293,588		293,588		0	201.00
202.00	Total (see instructions)	80,231,740	0	80,231,740	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | 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	6,820,239		6,820,239			30.00
31.00	INTENSIVE CARE UNIT	1,794,713		1,794,713			31.00
40.00	SUBPROVIDER - IPF	1,281,086		1,281,086			40.00
43.00	NURSERY	432,137		432,137			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,989,051	5,515,940	13,504,991	0.190718	0.000000	50.00
51.00	RECOVERY ROOM	1,257,484	1,575,686	2,833,170	0.650971	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	713,021	164,181	877,202	1.638257	0.000000	52.00
53.00	ANESTHESIOLOGY	1,909,392	1,252,748	3,162,140	0.263086	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,104,035	4,071,513	6,175,548	0.698697	0.000000	54.00
56.00	RADIOISOTOPE	844,168	1,440,911	2,285,079	0.125611	0.000000	56.00
57.00	CT SCAN	4,660,384	10,143,643	14,804,027	0.066445	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	932,391	2,721,500	3,653,891	0.108447	0.000000	58.00
60.00	LABORATORY	14,202,010	16,097,315	30,299,325	0.166675	0.000000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	893,749	531,733	1,425,482	0.760769	0.000000	62.00
65.00	RESPIRATORY THERAPY	1,126,041	168,987	1,295,028	1.250515	0.000000	65.00
66.00	PHYSICAL THERAPY	991,829	2,752,083	3,743,912	0.822700	0.000000	66.00
68.00	SPEECH PATHOLOGY	69,767	245,781	315,548	0.714417	0.000000	68.00
69.00	ELECTROCARDIOLOGY	9,596,667	9,935,197	19,531,864	0.173096	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	31,655	696,315	727,970	0.378731	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,125,433	21,363,299	62,488,732	0.144846	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	577,151	1,783,521	2,360,672	0.442904	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	26,913,643	11,100,448	38,014,091	0.190175	0.000000	73.00
76.00	CANCER CENTER	113,914	5,373,933	5,487,847	0.424836	0.000000	76.00
76.01	DIABETES CENTER	0	22,066	22,066	4.145699	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	837,127	837,127	1.374801	0.000000	88.00
88.01	RURAL HEALTH CLINIC II	0	587,033	587,033	1.425770	0.000000	88.01
88.02	RURAL HEALTH CLINIC III	0	1,136,251	1,136,251	1.033611	0.000000	88.02
91.00	EMERGENCY	866,907	2,068,058	2,934,965	2.280183	0.000000	91.00
91.01	OUTPATIENT PSYCH	0	269,542	269,542	4.010351	0.000000	91.01
91.02	WOUND CARE	203	43,652	43,855	0.842572	0.000000	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,038	206,138	208,176	1.410287	0.000000	92.00
93.00	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,124,808	1,124,808			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	127,249,108	103,229,409	230,478,517			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	127,249,108	103,229,409	230,478,517			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet C Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | 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
40.00	SUBPROVIDER - IPF			40.00
43.00	NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	RADIOISOTOPE	0.000000		56.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	LABORATORY	0.000000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	CANCER CENTER	0.000000		76.00
76.01	DIABETES CENTER	0.000000		76.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0.000000		88.00
88.01	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	EMERGENCY	0.000000		91.00
91.01	OUTPATIENT PSYCH	0.000000		91.01
91.02	WOUND CARE	0.000000		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	FAMILY PRACTICE	0.000000		93.00
	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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,438,945	0	1,438,945	16,880	85.25	30.00
31.00	INTENSIVE CARE UNIT	308,072		308,072	2,177	141.51	31.00
40.00	SUBPROVIDER - IPF	235,151	0	235,151	2,167	108.51	40.00
43.00	NURSERY	22,835		22,835	1,502	15.20	43.00
200.00	Total (lines 30-199)	2,005,003		2,005,003	22,726		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	10,728	914,562		30.00
31.00	INTENSIVE CARE UNIT	1,408	199,246		31.00
40.00	SUBPROVIDER - IPF	704	76,391		40.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	12,840	1,190,199		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part II Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	585,743	13,504,991	0.043372	4,613,390	200,092	50.00
51.00	RECOVERY ROOM	245,167	2,833,170	0.086535	663,472	57,414	51.00
52.00	DELIVERY ROOM & LABOR ROOM	39,226	877,202	0.044717	4,846	217	52.00
53.00	ANESTHESIOLOGY	24,575	3,162,140	0.007772	959,305	7,456	53.00
54.00	RADIOLOGY-DIAGNOSTIC	577,473	6,175,548	0.093510	1,877,532	175,568	54.00
56.00	RADIOISOTOPE	17,070	2,285,079	0.007470	692,925	5,176	56.00
57.00	CT SCAN	53,911	14,804,027	0.003642	2,858,478	10,411	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	105,111	3,653,891	0.028767	613,340	17,644	58.00
60.00	LABORATORY	330,435	30,299,325	0.010906	9,146,692	99,754	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,543	1,425,482	0.017217	610,847	10,517	62.00
65.00	RESPIRATORY THERAPY	108,919	1,295,028	0.084106	653,285	54,945	65.00
66.00	PHYSICAL THERAPY	285,946	3,743,912	0.076376	773,396	59,069	66.00
68.00	SPEECH PATHOLOGY	6,491	315,548	0.020571	57,768	1,188	68.00
69.00	ELECTROCARDIOLOGY	583,585	19,531,864	0.029879	5,956,899	177,986	69.00
70.00	ELECTROENCEPHALOGRAPHY	22,590	727,970	0.031031	19,586	608	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	224,794	62,488,732	0.003597	22,940,804	82,518	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	17,653	2,360,672	0.007478	432,137	3,232	72.00
73.00	DRUGS CHARGED TO PATIENTS	327,882	38,014,091	0.008625	14,227,992	122,716	73.00
76.00	CANCER CENTER	270,022	5,487,847	0.049204	81,340	4,002	76.00
76.01	DIABETES CENTER	3,266	22,066	0.148011	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	44,375	837,127	0.053009	0	0	88.00
88.01	RURAL HEALTH CLINIC II	21,874	587,033	0.037262	0	0	88.01
88.02	RURAL HEALTH CLINIC III	48,196	1,136,251	0.042417	0	0	88.02
91.00	EMERGENCY	1,334,639	2,934,965	0.454738	499,040	226,932	91.00
91.01	OUTPATIENT PSYCH	32,919	269,542	0.122129	0	0	91.01
91.02	WOUND CARE	773	43,855	0.017626	178	3	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	31,115	208,176	0.149465	2,038	305	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	5,368,293	219,025,534		67,685,290	1,317,753	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	NURSERY	0	0	0		0	43.00
200.00	Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	16,880	0.00	10,728	0	0	30.00
31.00	INTENSIVE CARE UNIT	2,177	0.00	1,408	0	0	31.00
40.00	SUBPROVIDER - IPF	2,167	0.00	704	0	0	40.00
43.00	NURSERY	1,502	0.00	0	0	0	43.00
200.00	Total (lines 30-199)	22,726		12,840	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part III Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
		12.00	13.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CANCER CENTER	0	0	0	0	0	76.00
76.01	DIABETES CENTER	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	0	0	0	0	91.00
91.01	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	WOUND CARE	0	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	13,504,991	0.000000	0.000000	4,613,390	50.00
51.00	RECOVERY ROOM	0	2,833,170	0.000000	0.000000	663,472	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	877,202	0.000000	0.000000	4,846	52.00
53.00	ANESTHESIOLOGY	0	3,162,140	0.000000	0.000000	959,305	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	6,175,548	0.000000	0.000000	1,877,532	54.00
56.00	RADIOISOTOPE	0	2,285,079	0.000000	0.000000	692,925	56.00
57.00	CT SCAN	0	14,804,027	0.000000	0.000000	2,858,478	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,653,891	0.000000	0.000000	613,340	58.00
60.00	LABORATORY	0	30,299,325	0.000000	0.000000	9,146,692	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,425,482	0.000000	0.000000	610,847	62.00
65.00	RESPIRATORY THERAPY	0	1,295,028	0.000000	0.000000	653,285	65.00
66.00	PHYSICAL THERAPY	0	3,743,912	0.000000	0.000000	773,396	66.00
68.00	SPEECH PATHOLOGY	0	315,548	0.000000	0.000000	57,768	68.00
69.00	ELECTROCARDIOLOGY	0	19,531,864	0.000000	0.000000	5,956,899	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	727,970	0.000000	0.000000	19,586	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,488,732	0.000000	0.000000	22,940,804	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,360,672	0.000000	0.000000	432,137	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	38,014,091	0.000000	0.000000	14,227,992	73.00
76.00	CANCER CENTER	0	5,487,847	0.000000	0.000000	81,340	76.00
76.01	DIABETES CENTER	0	22,066	0.000000	0.000000	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	837,127	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	587,033	0.000000	0.000000	0	88.01
88.02	RURAL HEALTH CLINIC III	0	1,136,251	0.000000	0.000000	0	88.02
91.00	EMERGENCY	0	2,934,965	0.000000	0.000000	499,040	91.00
91.01	OUTPATIENT PSYCH	0	269,542	0.000000	0.000000	0	91.01
91.02	WOUND CARE	0	43,855	0.000000	0.000000	178	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	208,176	0.000000	0.000000	2,038	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	219,025,534			67,685,290	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	2,646,141	0	0	0	50.00
51.00	RECOVERY ROOM	0	689,087	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	3,752	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	375,130	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,458,078	0	0	0	54.00
56.00	RADIOISOTOPE	0	800,639	0	0	0	56.00
57.00	CT SCAN	0	2,827,601	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	813,941	0	0	0	58.00
60.00	LABORATORY	0	916,283	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	352,607	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	50,799	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	17,893	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	4,024	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,341,924	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	188,055	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,307,772	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,276,336	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,542,095	0	0	0	73.00
76.00	CANCER CENTER	0	2,806,432	0	0	0	76.00
76.01	DIABETES CENTER	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	526,650	0	0	0	91.00
91.01	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	WOUND CARE	0	17,488	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	116,552	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00	Total (lines 50-199)	0	31,079,279	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	CANCER CENTER	0	0		76.00
76.01	DIABETES CENTER	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0		88.02
91.00	EMERGENCY	0	0		91.00
91.01	OUTPATIENT PSYCH	0	0		91.01
91.02	WOUND CARE	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	FAMILY PRACTICE	0	0		93.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.190718	2,646,141	0	0		50.00
51.00	RECOVERY ROOM	0.650971	689,087	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.638257	3,752	0	0		52.00
53.00	ANESTHESIOLOGY	0.263086	375,130	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.698697	1,458,078	0	0		54.00
56.00	RADIOISOTOPE	0.125611	800,639	0	0		56.00
57.00	CT SCAN	0.066445	2,827,601	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.108447	813,941	0	0		58.00
60.00	LABORATORY	0.166675	916,283	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.760769	352,607	0	0		62.00
65.00	RESPIRATORY THERAPY	1.250515	50,799	0	0		65.00
66.00	PHYSICAL THERAPY	0.822700	17,893	0	0		66.00
68.00	SPEECH PATHOLOGY	0.714417	4,024	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.173096	5,341,924	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.378731	188,055	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144846	6,307,772	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.442904	1,276,336	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190175	3,542,095	0	19,146		73.00
76.00	CANCER CENTER	0.424836	2,806,432	0	0		76.00
76.01	DIABETES CENTER	4.145699	0	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	RURAL HEALTH CLINIC III	0.000000					88.02
91.00	EMERGENCY	2.280183	526,650	0	0		91.00
91.01	OUTPATIENT PSYCH	4.010351	0	0	0		91.01
91.02	WOUND CARE	0.842572	17,488	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.410287	116,552	0	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
200.00	Subtotal (see instructions)		31,079,279	0	19,146		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		31,079,279	0	19,146		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | 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	504,667	0	0		50.00
51.00	RECOVERY ROOM	448,576	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	6,147	0	0		52.00
53.00	ANESTHESIOLOGY	98,691	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,018,755	0	0		54.00
56.00	RADIOISOTOPE	100,569	0	0		56.00
57.00	CT SCAN	187,880	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	88,269	0	0		58.00
60.00	LABORATORY	152,721	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	268,252	0	0		62.00
65.00	RESPIRATORY THERAPY	63,525	0	0		65.00
66.00	PHYSICAL THERAPY	14,721	0	0		66.00
68.00	SPEECH PATHOLOGY	2,875	0	0		68.00
69.00	ELECTROCARDIOLOGY	924,666	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	71,222	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	913,656	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	565,294	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	673,618	0	3,641		73.00
76.00	CANCER CENTER	1,192,273	0	0		76.00
76.01	DIABETES CENTER	0	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
91.00	EMERGENCY	1,200,858	0	0		91.00
91.01	OUTPATIENT PSYCH	0	0	0		91.01
91.02	WOUND CARE	14,735	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	164,372	0	0		92.00
93.00	FAMILY PRACTICE	0	0	0		93.00
200.00	Subtotal (see instructions)	8,676,342	0	3,641		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	8,676,342	0	3,641		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part II Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	585,743	13,504,991	0.043372	0	0	50.00
51.00	RECOVERY ROOM	245,167	2,833,170	0.086535	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	39,226	877,202	0.044717	0	0	52.00
53.00	ANESTHESIOLOGY	24,575	3,162,140	0.007772	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	577,473	6,175,548	0.093510	6,304	589	54.00
56.00	RADIOISOTOPE	17,070	2,285,079	0.007470	883	7	56.00
57.00	CT SCAN	53,911	14,804,027	0.003642	7,289	27	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	105,111	3,653,891	0.028767	2,563	74	58.00
60.00	LABORATORY	330,435	30,299,325	0.010906	103,116	1,125	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	24,543	1,425,482	0.017217	0	0	62.00
65.00	RESPIRATORY THERAPY	108,919	1,295,028	0.084106	1,247	105	65.00
66.00	PHYSICAL THERAPY	285,946	3,743,912	0.076376	1,255	96	66.00
68.00	SPEECH PATHOLOGY	6,491	315,548	0.020571	0	0	68.00
69.00	ELECTROCARDIOLOGY	583,585	19,531,864	0.029879	9,867	295	69.00
70.00	ELECTROENCEPHALOGRAPHY	22,590	727,970	0.031031	348	11	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	224,794	62,488,732	0.003597	7,589	27	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	17,653	2,360,672	0.007478	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	327,882	38,014,091	0.008625	68,848	594	73.00
76.00	CANCER CENTER	270,022	5,487,847	0.049204	0	0	76.00
76.01	DIABETES CENTER	3,266	22,066	0.148011	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	44,375	837,127	0.053009	0	0	88.00
88.01	RURAL HEALTH CLINIC II	21,874	587,033	0.037262	0	0	88.01
88.02	RURAL HEALTH CLINIC III	48,196	1,136,251	0.042417	0	0	88.02
91.00	EMERGENCY	1,334,639	2,934,965	0.454738	8,570	3,897	91.00
91.01	OUTPATIENT PSYCH	32,919	269,542	0.122129	0	0	91.01
91.02	WOUND CARE	773	43,855	0.017626	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	31,115	208,176	0.149465	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	5,368,293	219,025,534		217,879	6,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CANCER CENTER	0	0	0	0	0	76.00
76.01	DIABETES CENTER	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	0	0	0	0	91.00
91.01	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	WOUND CARE	0	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
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: 260025 Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	13,504,991	0.000000	0.000000	0	50.00
51.00	RECOVERY ROOM	0	2,833,170	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	877,202	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	3,162,140	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	6,175,548	0.000000	0.000000	6,304	54.00
56.00	RADIOISOTOPE	0	2,285,079	0.000000	0.000000	883	56.00
57.00	CT SCAN	0	14,804,027	0.000000	0.000000	7,289	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,653,891	0.000000	0.000000	2,563	58.00
60.00	LABORATORY	0	30,299,325	0.000000	0.000000	103,116	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,425,482	0.000000	0.000000	0	62.00
65.00	RESPIRATORY THERAPY	0	1,295,028	0.000000	0.000000	1,247	65.00
66.00	PHYSICAL THERAPY	0	3,743,912	0.000000	0.000000	1,255	66.00
68.00	SPEECH PATHOLOGY	0	315,548	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	19,531,864	0.000000	0.000000	9,867	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	727,970	0.000000	0.000000	348	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,488,732	0.000000	0.000000	7,589	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,360,672	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	38,014,091	0.000000	0.000000	68,848	73.00
76.00	CANCER CENTER	0	5,487,847	0.000000	0.000000	0	76.00
76.01	DIABETES CENTER	0	22,066	0.000000	0.000000	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	837,127	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	587,033	0.000000	0.000000	0	88.01
88.02	RURAL HEALTH CLINIC III	0	1,136,251	0.000000	0.000000	0	88.02
91.00	EMERGENCY	0	2,934,965	0.000000	0.000000	8,570	91.00
91.01	OUTPATIENT PSYCH	0	269,542	0.000000	0.000000	0	91.01
91.02	WOUND CARE	0	43,855	0.000000	0.000000	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	208,176	0.000000	0.000000	0	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	219,025,534			217,879	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	26	0	0	0	73.00
76.00	CANCER CENTER	0	0	0	0	0	76.00
76.01	DIABETES CENTER	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	EMERGENCY	0	0	0	0	0	91.00
91.01	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	WOUND CARE	0	0	0	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00	Total (lines 50-199)	0	26	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part IV | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	CANCER CENTER	0	0		76.00
76.01	DIABETES CENTER	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0		88.02
91.00	EMERGENCY	0	0		91.00
91.01	OUTPATIENT PSYCH	0	0		91.01
91.02	WOUND CARE	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	FAMILY PRACTICE	0	0		93.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | 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	0.190718	0	0	0		50.00
51.00	RECOVERY ROOM	0.650971	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.638257	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.263086	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.698697	0	0	0		54.00
56.00	RADIOISOTOPE	0.125611	0	0	0		56.00
57.00	CT SCAN	0.066445	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.108447	0	0	0		58.00
60.00	LABORATORY	0.166675	0	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.760769	0	0	0		62.00
65.00	RESPIRATORY THERAPY	1.250515	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.822700	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0.714417	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.173096	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.378731	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144846	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.442904	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190175	26	0	16		73.00
76.00	CANCER CENTER	0.424836	0	0	0		76.00
76.01	DIABETES CENTER	4.145699	0	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	RURAL HEALTH CLINIC III	0.000000					88.02
91.00	EMERGENCY	2.280183	0	0	0		91.00
91.01	OUTPATIENT PSYCH	4.010351	0	0	0		91.01
91.02	WOUND CARE	0.842572	0	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.410287	0	0	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
200.00	Subtotal (see instructions)		26	0	16		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		26	0	16		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D Part V | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | 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
51.00	RECOVERY ROOM	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	LABORATORY	0	0	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	5	0	3		73.00
76.00	CANCER CENTER	0	0	0		76.00
76.01	DIABETES CENTER	0	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
91.00	EMERGENCY	0	0	0		91.00
91.01	OUTPATIENT PSYCH	0	0	0		91.01
91.02	WOUND CARE	0	0	0		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	FAMILY PRACTICE	0	0	0		93.00
200.00	Subtotal (see instructions)	5	0	3		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	5	0	3		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,880	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,880	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)	16,880	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)	10,728	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,577,371	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)	13,577,371	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,820,239	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,820,239	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.990747	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)	404.04	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)	13,577,371	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)	804.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,629,067	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)	8,629,067	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,165,762	2,177	1,913.53	1,408	2,694,250	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)	15,287,321	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,610,638	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)	1,113,808	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,317,753	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,431,561	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,179,077	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)	365	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	804.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	293,588	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,438,945	13,577,371	0.105981	293,588	31,115	90.00
91.00	Nursing School cost	0	13,577,371	0.000000	293,588	0	91.00
92.00	Allied health cost	0	13,577,371	0.000000	293,588	0	92.00
93.00	All other Medical Education	0	13,577,371	0.000000	293,588	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 260025	Period: From 10/01/2010	Worksheet D-1
Component CCN: 26S025	To 09/30/2011	Date/Time Prepared: 3/29/2012 10:16 am
Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,167	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,167	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)	2,167	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)	704	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,945,459	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)	1,945,459	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,281,086	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,281,086	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.518601	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)	591.18	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,945,459	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)	897.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	632,030	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)	632,030	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 260025 | Component CCN: 26S025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	62,196	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	694,226	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)	76,391	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,847	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	83,238	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	610,988	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 260025 | Period: From 10/01/2010 | Worksheet D-1
Component CCN: 26S025 | To 09/30/2011 | Date/Time Prepared: 3/29/2012 10:16 am
Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	235,151	1,945,459	0.120872	0	0	90.00
91.00	Nursing School cost	0	1,945,459	0.000000	0	0	91.00
92.00	Allied health cost	0	1,945,459	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,945,459	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | 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)	16,880	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,880	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)	16,880	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)	1,361	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)	1,502	15.00
16.00	Nursery days (title V or XIX only)	140	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,577,371	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)	13,577,371	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,820,239	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,820,239	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.990747	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)	404.04	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)	13,577,371	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)	804.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,094,720	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)	1,094,720	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	657,666	1,502	437.86	140	61,300	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,165,762	2,177	1,913.53	245	468,815	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,624,835	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)	365	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	804.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	293,588	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XIX | 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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 260025	Period: From 10/01/2010	Worksheet D-1
Component CCN: 26S025	To 09/30/2011	Date/Time Prepared: 3/29/2012 10:16 am
Title XIX	Subprovider - IPF	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)	2,167	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,167	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)	2,167	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)	749	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)	1,502	15.00
16.00	Nursery days (title V or XIX only)	140	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,945,459	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)	1,945,459	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,281,086	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,281,086	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.518601	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)	591.18	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,945,459	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)	897.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	672,430	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)	672,430	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 260025 | Period: From 10/01/2010 | Worksheet D-1
Component CCN: 26S025 | To 09/30/2011 | Date/Time Prepared: 3/29/2012 10:16 am
Title XIX | Subprovider - IPF | 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	0	0	0.00	0	0	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	672,430	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 260025 Component CCN: 26S025	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 3/29/2012 10:16 am
	Title XIX	Subprovider - IPF	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		4,640,960		30.00
31.00	INTENSIVE CARE UNIT		1,182,281		31.00
40.00	SUBPROVIDER - IPF		0		40.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.190718	4,613,390	879,857	50.00
51.00	RECOVERY ROOM	0.650971	663,472	431,901	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.638257	4,846	7,939	52.00
53.00	ANESTHESIOLOGY	0.277436	959,305	266,146	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.698697	1,877,532	1,311,826	54.00
56.00	RADIOISOTOPE	0.125611	692,925	87,039	56.00
57.00	CT SCAN	0.066445	2,858,478	189,932	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.108447	613,340	66,515	58.00
60.00	LABORATORY	0.178272	9,146,692	1,630,599	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.760769	610,847	464,713	62.00
65.00	RESPIRATORY THERAPY	1.250515	653,285	816,943	65.00
66.00	PHYSICAL THERAPY	0.822700	773,396	636,273	66.00
68.00	SPEECH PATHOLOGY	0.714417	57,768	41,270	68.00
69.00	ELECTROCARDIOLOGY	0.173096	5,956,899	1,031,115	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.378731	19,586	7,418	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144846	22,940,804	3,322,884	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.442904	432,137	191,395	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190175	14,227,992	2,705,808	73.00
76.00	CANCER CENTER	0.433137	81,340	35,231	76.00
76.01	DIABETES CENTER	4.145699	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	EMERGENCY	2.323448	499,040	1,159,493	91.00
91.01	OUTPATIENT PSYCH	4.010351	0	0	91.01
91.02	WOUND CARE	0.842572	178	150	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.410287	2,038	2,874	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		67,685,290	15,287,321	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)		67,685,290		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet D-3

Component CCN: 26S025 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Subprovider - IPF | 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
40.00	SUBPROVIDER - IPF		349,216		40.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.190718	0	0	50.00
51.00	RECOVERY ROOM	0.650971	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.638257	0	0	52.00
53.00	ANESTHESIOLOGY	0.277436	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.698697	6,304	4,405	54.00
56.00	RADIOISOTOPE	0.125611	883	111	56.00
57.00	CT SCAN	0.066445	7,289	484	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.108447	2,563	278	58.00
60.00	LABORATORY	0.178272	103,116	18,383	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.760769	0	0	62.00
65.00	RESPIRATORY THERAPY	1.250515	1,247	1,559	65.00
66.00	PHYSICAL THERAPY	0.822700	1,255	1,032	66.00
68.00	SPEECH PATHOLOGY	0.714417	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.173096	9,867	1,708	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.378731	348	132	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.144846	7,589	1,099	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.442904	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190175	68,848	13,093	73.00
76.00	CANCER CENTER	0.433137	0	0	76.00
76.01	DIABETES CENTER	4.145699	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	EMERGENCY	2.323448	8,570	19,912	91.00
91.01	OUTPATIENT PSYCH	4.010351	0	0	91.01
91.02	WOUND CARE	0.842572	0	0	91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.410287	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		217,879	62,196	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)		217,879		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	22,976,833		1.00
2.00	Outlier payments for discharges. (see instructions)	258,696		2.00
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	90.00		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.33		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	17.61		31.00
32.00	Sum of lines 30 and 31	22.94		32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.14		33.00
34.00	Disproportionate share adjustment (see instructions)	1,870,314		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	25,105,843		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	25,032,930		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	25,105,843		49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,544,890		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	26,650,733		59.00
60.00	Primary payer payments	8,791		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	26,641,942		61.00
62.00	Deductibles billed to program beneficiaries	2,228,510		62.00
63.00	Coinsurance billed to program beneficiaries	45,921		63.00
64.00	Allowable bad debts (see instructions)	643,915		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	450,741		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	616,897		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	24,818,252		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	24,818,252		71.00
72.00	Interim payments	24,040,198		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	778,054		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	726,417		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,641	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,676,342	2.00
3.00	PPS payments	6,781,778	3.00
4.00	Outlier payment (see instructions)	271,849	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.882	5.00
6.00	Line 2 times line 5	7,652,534	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	92.17	7.00
8.00	Transitional corridor payment (see instructions)	509,071	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)	3,641	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	19,146	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)	19,146	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)	19,146	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	15,505	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)	3,641	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)	7,562,698	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,590,832	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)	5,975,507	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)	5,975,507	30.00
31.00	Primary payer payments	488	31.00
32.00	Subtotal (line 30 minus line 31)	5,975,019	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)	130,347	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	91,243	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,187	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	6,066,262	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)	6,066,262	40.00
41.00	Interim payments	6,167,249	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)	-100,987	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: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025 Component CCN:26S025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5	2.00
3.00	PPS payments	23	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)	3	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	16	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)	16	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)	16	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13	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)	3	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)	23	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	26	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)	26	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	26	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)	26	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)	26	40.00
41.00	Interim payments	26	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)	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: 260025 Component CCN: 26S025	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Subprovider - IPF	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		24,040,198		6,167,249	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)		24,040,198		6,167,249	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		778,054		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		100,987	6.02
7.00	Total Medicare program liability (see instructions)		24,818,252		6,066,262	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 3/29/2012 10:16 am

Component CCN: 26S025 | Title XVIII | Subprovider - IPF | 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		431,285		26	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)		431,285		26	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		21,371		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		452,656		26	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025 Component CCN:26S025	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part II Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	508,689	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.936986	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	508,689	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	508,689	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	508,689	18.00
19.00	Deductibles	75,140	19.00
20.00	Subtotal (line 18 minus line 19)	433,549	20.00
21.00	Coinsurance	2,264	21.00
22.00	Subtotal (line 20 minus line 21)	431,285	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,530	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	21,371	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,530	25.00
26.00	Subtotal (sum of lines 22 and 24)	452,656	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	452,656	31.00
32.00	Interim payments	431,285	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	21,371	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G | Date/Time Prepared: 3/29/2012 10:16 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	7,660,293	0	0	0	1.00
2.00	Temporary investments	2,035,718	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,220,905	0	0	0	4.00
5.00	Other receivable	1,450,730	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,403,874	0	0	0	7.00
8.00	Prepaid expenses	586,866	0	0	0	8.00
9.00	Other current assets	951,386	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)	29,309,772	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,172,770	0	0	0	12.00
13.00	Land improvements	7,204,367	0	0	0	13.00
14.00	Accumulated depreciation	-4,369,687	0	0	0	14.00
15.00	Buildings	42,940,418	0	0	0	15.00
16.00	Accumulated depreciation	-22,259,456	0	0	0	16.00
17.00	Leasehold improvements	18,526,503	0	0	0	17.00
18.00	Accumulated depreciation	-5,808,292	0	0	0	18.00
19.00	Fixed equipment	98,327	0	0	0	19.00
20.00	Accumulated depreciation	-91,735	0	0	0	20.00
21.00	Automobiles and trucks	443,145	0	0	0	21.00
22.00	Accumulated depreciation	-390,624	0	0	0	22.00
23.00	Major movable equipment	50,083,899	0	0	0	23.00
24.00	Accumulated depreciation	-36,420,127	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)	52,129,508	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	28,301,403	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	12,077,707	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	40,379,110	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	121,818,390	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,370,184	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,050,836	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	95,718	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	4,017,683	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,534,421	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,241,845	0	0	0	47.00
48.00	Unsecured loans	6,717,634	0	0	0	48.00
49.00	Other long term liabilities	9,273,700	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	39,233,179	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	54,767,600	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	67,050,790				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)	67,050,790	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	121,818,390	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-1 | Date/Time Prepared: 3/29/2012 10:16 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		65,722,203		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		478,815				2.00
3.00	Total (sum of line 1 and line 2)		66,201,018		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)		66,201,018		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)		66,201,018		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-1 | Date/Time Prepared: 3/29/2012 10:16 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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 3/29/2012 10:16 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,252,376		7,252,376	1.00
2.00	SUBPROVIDER - IPF	1,281,086		1,281,086	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				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,533,462		8,533,462	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,794,713		1,794,713	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,794,713		1,794,713	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,328,175		10,328,175	17.00
18.00	Ancillary services	116,051,784	96,956,799	213,008,583	18.00
19.00	Outpatient services	869,148	2,587,390	3,456,538	19.00
20.00	RURAL HEALTH CLINIC	0	837,127	837,127	20.00
20.01	RURAL HEALTH CLINIC II	0	587,033	587,033	20.01
20.02	RURAL HEALTH CLINIC III	0	1,136,251	1,136,251	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,124,808	1,124,808	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	PHYSICIAN REVENUE	1,799,558	2,932,312	4,731,870	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	7,498,116	7,498,116	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	129,048,665	113,659,836	242,708,501	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		103,966,937		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		103,966,937		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet G-3 Date/Time Prepared: 3/29/2012 10:16 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	242,708,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	134,249,311	2.00
3.00	Net patient revenues (line 1 minus line 2)	108,459,190	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	103,966,937	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,492,253	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	608,133	6.00
7.00	Income from investments	29,982	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	543,867	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	RENTAL INCOME	227,495	24.00
24.01	NONOPERATING INCOME	-749,810	24.01
24.02	OTHER REVENUE	1,811,881	24.02
25.00	Total other income (sum of lines 6-24)	2,471,548	25.00
26.00	Total (line 5 plus line 25)	6,963,801	26.00
27.00	BAD DEBTS	6,484,986	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	6,484,986	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	478,815	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 260025 | Period: From 10/01/2010 | Worksheet H
HHA CCN: 267282 | To 09/30/2011 | Date/Time Prepared: 3/29/2012 10:16 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	201,679	26,053	0	0	122,420	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	349,656	45,169	0	0	18,087	6.00
7.00	Physical Therapy	176,905	22,853	0	0	0	7.00
8.00	Occupational Therapy	34,033	4,396	0	0	5,112	8.00
9.00	Speech Pathology	23,230	3,001	0	0	1,019	9.00
10.00	Medical Social Services	2,242	290	0	0	0	10.00
11.00	Home Health Aide	24,728	3,195	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	17,531	12.00
13.00	Drugs	0	0	0	0	140	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	812,473	104,957	0	0	164,309	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: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H

HHA CCN: 267282 | Date/Time Prepared: 3/29/2012 10:16 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	350,152	0	350,152	0	350,152	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	412,912	0	412,912	0	412,912	6.00
7.00	Physical Therapy	199,758	0	199,758	0	199,758	7.00
8.00	Occupational Therapy	43,541	0	43,541	0	43,541	8.00
9.00	Speech Pathology	27,250	0	27,250	0	27,250	9.00
10.00	Medical Social Services	2,532	0	2,532	0	2,532	10.00
11.00	Home Health Aide	27,923	0	27,923	0	27,923	11.00
12.00	Supplies (see instructions)	17,531	0	17,531	0	17,531	12.00
13.00	Drugs	140	0	140	0	140	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,081,739	0	1,081,739	0	1,081,739	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-1 Part I Date/Time Prepared: 3/29/2012 10:16 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	350,152	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	412,912	0	0	0	0	6.00
7.00	Physical Therapy	199,758	0	0	0	0	7.00
8.00	Occupational Therapy	43,541	0	0	0	0	8.00
9.00	Speech Pathology	27,250	0	0	0	0	9.00
10.00	Medical Social Services	2,532	0	0	0	0	10.00
11.00	Home Health Aide	27,923	0	0	0	0	11.00
12.00	Supplies (see instructions)	17,531	0	0	0	0	12.00
13.00	Drugs	140	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,081,739	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 260025 HHA CCN: 267282

Period: From 10/01/2010 To 09/30/2011

Worksheet H-1 Part I Date/Time Prepared: 3/29/2012 10:16 am

Home Health Agency I

PPS

		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	350,152	350,152			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	412,912	197,627	610,539		6.00
7.00	Physical Therapy	199,758	95,608	295,366		7.00
8.00	Occupational Therapy	43,541	20,840	64,381		8.00
9.00	Speech Pathology	27,250	13,042	40,292		9.00
10.00	Medical Social Services	2,532	1,212	3,744		10.00
11.00	Home Health Aide	27,923	13,365	41,288		11.00
12.00	Supplies (see instructions)	17,531	8,391	25,922		12.00
13.00	Drugs	140	67	207		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	731,587		1,081,739		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-1 Part II | Date/Time Prepared: 3/29/2012 10:16 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	100				0	1.00
2.00	Capital Related - Movable Equipment		100			0	2.00
3.00	Plant Operation & Maintenance	0	0	100		0	3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	100	100	100	100	-350,152	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	100	100	100	100	-350,152	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-1 Part II Date/Time Prepared: 3/29/2012 10:16 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	731,587		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	412,912		6.00
7.00	Physical Therapy	199,758		7.00
8.00	Occupational Therapy	43,541		8.00
9.00	Speech Pathology	27,250		9.00
10.00	Medical Social Services	2,532		10.00
11.00	Home Health Aide	27,923		11.00
12.00	Supplies (see instructions)	17,531		12.00
13.00	Drugs	140		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	731,587		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	350,152		25.00
26.00	Unit Cost Multiplier	0.478620		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I
HHA CCN: 267282 | Date/Time Prepared: 3/29/2012 10:16 am

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			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	0	15,873	44,351	60,224	1.00
2.00	Skilled Nursing Care	610,539	0	0	76,046	686,585	2.00
3.00	Physical Therapy	295,366	0	0	38,475	333,841	3.00
4.00	Occupational Therapy	64,381	0	0	7,402	71,783	4.00
5.00	Speech Pathology	40,292	0	0	5,052	45,344	5.00
6.00	Medical Social Services	3,744	0	0	0	3,744	6.00
7.00	Home Health Aide	41,288	0	0	5,378	46,666	7.00
8.00	Supplies (see instructions)	25,922	0	0	0	25,922	8.00
9.00	Drugs	207	0	0	0	207	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,081,739	0	15,873	176,704	1,274,316	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

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		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	17,064	5,586	52,742	0	0	1.00
2.00	Skilled Nursing Care	194,534	0	0	0	0	2.00
3.00	Physical Therapy	94,590	0	0	0	0	3.00
4.00	Occupational Therapy	20,339	0	0	0	0	4.00
5.00	Speech Pathology	12,848	0	0	0	0	5.00
6.00	Medical Social Services	1,061	0	0	0	0	6.00
7.00	Home Health Aide	13,222	0	0	0	0	7.00
8.00	Supplies (see instructions)	7,345	0	0	0	0	8.00
9.00	Drugs	59	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	361,062	5,586	52,742	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: 260025 HHA CCN: 267282

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

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		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	83,329	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	83,329	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

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		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	218,945	0	218,945		1.00
2.00	Skilled Nursing Care	0	881,119	0	881,119	123,816	2.00
3.00	Physical Therapy	0	428,431	0	428,431	60,204	3.00
4.00	Occupational Therapy	0	92,122	0	92,122	12,945	4.00
5.00	Speech Pathology	0	58,192	0	58,192	8,177	5.00
6.00	Medical Social Services	0	4,805	0	4,805	675	6.00
7.00	Home Health Aide	0	59,888	0	59,888	8,416	7.00
8.00	Supplies (see instructions)	0	33,267	0	33,267	4,675	8.00
9.00	Drugs	0	266	0	266	37	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	1,777,035	0	1,777,035	218,945	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.					0.140521	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 3/29/2012 10:16 am

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		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	1,004,935		2.00
3.00	Physical Therapy	488,635		3.00
4.00	Occupational Therapy	105,067		4.00
5.00	Speech Pathology	66,369		5.00
6.00	Medical Social Services	5,480		6.00
7.00	Home Health Aide	68,304		7.00
8.00	Supplies (see instructions)	37,942		8.00
9.00	Drugs	303		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19) (2)	1,777,035		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 STATISTICAL BASIS

Provider CCN: 260025 HHA CCN: 267282

Period: From 10/01/2010 To 09/30/2011

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		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	14,634	203,921	0	60,224	1.00
2.00	Skilled Nursing Care	0	0	349,656	0	686,585	2.00
3.00	Physical Therapy	0	0	176,905	0	333,841	3.00
4.00	Occupational Therapy	0	0	34,033	0	71,783	4.00
5.00	Speech Pathology	0	0	23,230	0	45,344	5.00
6.00	Medical Social Services	0	0	0	0	3,744	6.00
7.00	Home Health Aide	0	0	24,728	0	46,666	7.00
8.00	Supplies (see instructions)	0	0	0	0	25,922	8.00
9.00	Drugs	0	0	0	0	207	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	14,634	812,473		1,274,316	20.00
21.00	Total cost to be allocated	0	15,873	176,704		361,062	21.00
22.00	Unit cost multiplier	0.000000	1.084666	0.217489		0.283338	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 260025 HHA CCN: 267282

Period: From 10/01/2010 To 09/30/2011

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		MAINTENANCE & REPAIRS (DOLLAR VALUE)	OPERATION OF PLANT (DOLLAR VALUE)	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	3,650	3,650	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,650	3,650	0	0	0	20.00
21.00	Total cost to be allocated	5,586	52,742	0	0	0	21.00
22.00	Unit cost multiplier	1.530411	14.449863	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 260025 HHA CCN: 267282

Period: From 10/01/2010 To 09/30/2011

Worksheet H-2 Part II Date/Time Prepared: 3/29/2012 10:16 am

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		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	52,897	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	52,897	0	0	0	20.00
21.00	Total cost to be allocated	0	83,329	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	1.575307	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II
HHA CCN: 267282 | Date/Time Prepared: 3/29/2012 10:16 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	1,004,935		1,004,935	4,126	1.00
2.00	Physical Therapy	3.00	488,635	0	488,635	2,178	2.00
3.00	Occupational Therapy	4.00	105,067	0	105,067	419	3.00
4.00	Speech Pathology	5.00	66,369	0	66,369	286	4.00
5.00	Medical Social Services	6.00	5,480		5,480	19	5.00
6.00	Home Health Aide	7.00	68,304		68,304	591	6.00
7.00	Total (sum of lines 1-6)		1,738,790	0	1,738,790	7,619	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: 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		99926	1,438	551		8.00
8.01	Skilled Nursing Care		99914	174	308		8.01
9.00	Physical Therapy		99926	661	316		9.00
9.01	Physical Therapy		99914	152	275		9.01
10.00	Occupational Therapy		99926	210	82		10.00
10.01	Occupational Therapy		99914	18	3		10.01
11.00	Speech Pathology		99926	59	21		11.00
11.01	Speech Pathology		99914	0	0		11.01
12.00	Medical Social Services		99926	12	5		12.00
12.01	Medical Social Services		99914	0	0		12.01
13.00	Home Health Aide		99926	279	156		13.00
13.01	Home Health Aide		99914	40	11		13.01
14.00	Total (sum of lines 8-13)			3,043	1,728		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	37,942	0	37,942	54,638	15.00
16.00	Cost of Drugs	9.00	303	0	303	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	0.822700	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology	68.00	0.714417	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.144846	0	0	4.00
5.00	Cost of Drugs	73.00	0.190175	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 3/29/2012 10:16 am

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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	243.56	1,612	859			1.00
2.00	Physical Therapy	224.35	813	591			2.00
3.00	Occupational Therapy	250.76	228	85			3.00
4.00	Speech Pathology	232.06	59	21			4.00
5.00	Medical Social Services	288.42	12	5			5.00
6.00	Home Health Aide	115.57	319	167			6.00
7.00	Total (sum of lines 1-6)		3,043	1,728			7.00

	Cost Center Description						
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

	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		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.694425	2,863	900	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	col. 2, line 4.00					3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00					4.00
5.00	Cost of Drugs	col. 2, line 16.00					5.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 3/29/2012 10:16 am

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	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	392,619	209,218		601,837		1.00
2.00	Physical Therapy	182,397	132,591		314,988		2.00
3.00	Occupational Therapy	57,173	21,315		78,488		3.00
4.00	Speech Pathology	13,692	4,873		18,565		4.00
5.00	Medical Social Services	3,461	1,442		4,903		5.00
6.00	Home Health Aide	36,867	19,300		56,167		6.00
7.00	Total (sum of lines 1-6)	686,209	388,739		1,074,948		7.00
	Cost Center Description	10.00	11.00	12.00			
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
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	1,988	625	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 260025 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-4 Part I-II
HHA CCN: 267282 | Date/Time Prepared: 3/29/2012 10:16 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	449,112	253,952	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)	449,112	253,952	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	449,112	253,952	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	454,283	288,731	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	2,317	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	8,456	5,968	13.00
14.00	Total PPS Reimbursement - PEP Episodes	3,096	2,534	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	1,249	0	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)	469,401	297,233	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	469,401	297,233	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	469,401	297,233	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)	469,401	297,233	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	469,401	297,233	31.00
32.00	Interim payments (see instructions)	469,401	297,233	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: 260025 HHA CCN: 267282 | Period: From 10/01/2010 To 09/30/2011 | Worksheet H-5 | Date/Time Prepared: 3/29/2012 10:16 am

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		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		469,401		297,233	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)		469,401		297,233	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)		469,401		297,233	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 260025	Period: From 10/01/2010 To 09/30/2011	Worksheet L Parts I-III Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,516,686	1.00
2.00	Capital DRG outlier payments	28,204	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	51.21	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	1,544,890	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 260025 Component CCN: 268512 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 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	248,345	0	248,345	0	248,345	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	80,302	0	80,302	0	80,302	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	118,755	0	118,755	0	118,755	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)	447,402	0	447,402	0	447,402	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	16,008	16,008	0	16,008	13.00
14.00	Subtotal (sum of lines 11-13)	0	16,008	16,008	0	16,008	14.00
15.00	Medical Supplies	0	6,261	6,261	0	6,261	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	15,234	15,234	0	15,234	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,495	21,495	0	21,495	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	447,402	37,503	484,905	0	484,905	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	70	70	0	70	29.00
30.00	Administrative Costs	98,572	152,724	251,296	0	251,296	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	98,572	152,794	251,366	0	251,366	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	545,974	190,297	736,271	0	736,271	32.00

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

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 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	248,345		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	80,302		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	118,755		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	447,402		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	16,008		13.00
14.00	Subtotal (sum of lines 11-13)	0	16,008		14.00
15.00	Medical Supplies	0	6,261		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	15,234		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	21,495		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	484,905		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	70		29.00
30.00	Administrative Costs	0	251,296		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	251,366		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	736,271		32.00

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

Provider CCN: 260025 Component CCN: 263984 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Rural Health Clinic (RHC) II | 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	186,498	0	186,498	0	186,498	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	97,350	0	97,350	0	97,350	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	73,994	0	73,994	0	73,994	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)	357,842	0	357,842	0	357,842	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	7,678	7,678	0	7,678	13.00
14.00	Subtotal (sum of lines 11-13)	0	7,678	7,678	0	7,678	14.00
15.00	Medical Supplies	0	2,276	2,276	0	2,276	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	8,459	8,459	0	8,459	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	10,735	10,735	0	10,735	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	357,842	18,413	376,255	0	376,255	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	56,920	83,712	140,632	0	140,632	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	56,920	83,712	140,632	0	140,632	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	414,762	102,125	516,887	0	516,887	32.00

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

Provider CCN: 260025 Component CCN: 263984 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	186,498		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	97,350		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	73,994		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	357,842		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	7,678		13.00
14.00	Subtotal (sum of lines 11-13)	0	7,678		14.00
15.00	Medical Supplies	0	2,276		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	8,459		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	10,735		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	376,255		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	140,632		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	140,632		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	516,887		32.00

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

Provider CCN: 260025 Component CCN: 268513 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Rural Health Clinic (RHC) III | 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	230,768	0	230,768	0	230,768	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	125,678	0	125,678	0	125,678	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	36,224	0	36,224	0	36,224	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)	392,670	0	392,670	0	392,670	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	26,789	26,789	0	26,789	13.00
14.00	Subtotal (sum of lines 11-13)	0	26,789	26,789	0	26,789	14.00
15.00	Medical Supplies	0	2,049	2,049	0	2,049	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	29,795	29,795	0	29,795	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	31,844	31,844	0	31,844	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	392,670	58,633	451,303	0	451,303	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	124,131	129,980	254,111	0	254,111	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	124,131	129,980	254,111	0	254,111	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	516,801	188,613	705,414	0	705,414	32.00

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

Provider CCN: 260025 Component CCN: 268513 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-1 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	230,768		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	125,678		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	36,224		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	392,670		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	26,789		13.00
14.00	Subtotal (sum of lines 11-13)	0	26,789		14.00
15.00	Medical Supplies	0	2,049		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	29,795		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	31,844		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	451,303		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	254,111		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	254,111		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	705,414		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-2 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.46	3,620	4,200	6,132		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.82	1,844	2,100	1,722		3.00
4.00	Subtotal (sum of lines 1-3)	2.28	5,464		7,854	7,854	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)	2.28	5,464			7,854	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)					484,905	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)					484,905	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)					251,366	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					414,612	15.00
16.00	Total overhead (sum of lines 14 and 15)					665,978	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					665,978	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					665,978	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,150,883	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Period: From 10/01/2010 | Worksheet M-2
Component CCN: 263984 | To 09/30/2011 | Date/Time Prepared: 3/29/2012 10:16 am
Title XVIII | Rural Health Clinic (RHC) II | 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	0.86	1,643	4,200	3,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.84	2,040	2,100	1,764		3.00
4.00	Subtotal (sum of lines 1-3)	1.70	3,683		5,376	5,376	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)	1.70	3,683			5,376	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)					376,255	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)					376,255	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)					140,632	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					320,087	15.00
16.00	Total overhead (sum of lines 14 and 15)					460,719	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					460,719	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					460,719	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					836,974	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-2 | Date/Time Prepared: 3/29/2012 10:16 am

Title XVIII | Rural Health Clinic (RHC) III | 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	0.87	3,754	4,200	3,654		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.83	1,624	2,100	1,743		3.00
4.00	Subtotal (sum of lines 1-3)	1.70	5,378		5,397	5,397	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)	1.70	5,378			5,397	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)					451,303	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)					451,303	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)					254,111	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					469,027	15.00
16.00	Total overhead (sum of lines 14 and 15)					723,138	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					723,138	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					723,138	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,174,441	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2010 To 09/30/2011	Worksheet M-3 Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,150,883	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		15,330	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,135,553	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,854	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)		7,854	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		144.58	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	412	1,236	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	32,037	96,495	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) *	32,037	96,495	16.00
16.01	Total program charges (see instructions)(from contractor's records)		183,967	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 lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		54,187	16.04
16.05	Total program cost (see instructions)	25,630	54,187	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,761	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		31,041	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		79,817	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,330	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		90,147	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)		90,147	26.00
27.00	Interim payments		78,508	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)		11,639	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2010 To 09/30/2011	Worksheet M-3 Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Rural Health Clinic (RHC) II	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)		836,974	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,121	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		827,853	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,376	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)		5,376	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		153.99	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	225	674	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	17,496	52,619	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) *	17,496	52,619	16.00
16.01	Total program charges (see instructions)(from contractor's records)		110,480	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 lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		27,655	16.04
16.05	Total program cost (see instructions)	13,997	27,655	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,050	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,461	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		41,652	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,647	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		47,299	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)		47,299	26.00
27.00	Interim payments		40,588	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)		6,711	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 260025 Component CCN: 268513 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-3 Date/Time Prepared: 3/29/2012 10:16 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,174,441	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		20,860	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,153,581	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,397	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)		5,397	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		213.74	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	78.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	403	1,208	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	31,337	94,309	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) *	31,337	94,309	16.00
16.01	Total program charges (see instructions)(from contractor's records)		223,525	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 lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		54,785	16.04
16.05	Total program cost (see instructions)	25,070	54,785	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,828	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,287	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		79,855	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,939	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		91,794	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)		91,794	26.00
27.00	Interim payments		78,243	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)		13,551	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-4 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	447,402	447,402	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000492	0.007062	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	220	3,160	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	743	2,336	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	963	5,496	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	484,905	484,905	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	665,978	665,978	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001986	0.011334	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,323	7,548	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,286	13,044	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	201	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	163.29	64.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	134	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,633	8,697	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		15,330	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		10,330	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 263984 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-4 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	357,842	357,842	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000329	0.005967	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	118	2,135	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	371	1,476	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	489	3,611	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	376,255	376,255	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	460,719	460,719	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001300	0.009597	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	599	4,422	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,088	8,033	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	7	127	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	155.43	63.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	77	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	777	4,870	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		9,121	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		5,647	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2010 To 09/30/2011 | Worksheet M-4 | Date/Time Prepared: 3/29/2012 10:16 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	392,670	392,670	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001789	0.008284	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	702	3,253	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,016	2,045	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,718	5,298	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	451,303	451,303	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	723,138	723,138	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006023	0.011739	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,355	8,489	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,073	13,787	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	38	176	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	186.13	78.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	25	93	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,653	7,286	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		20,860	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		11,939	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 3/29/2012 10:16 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		78,508	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)		78,508	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		11,639	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		90,147	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		40,588	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)		40,588	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		6,711	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,299	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 3/29/2012 10:16 am
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		78,243	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)		78,243	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		13,551	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		91,794	7.00

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