This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140001	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/26/2012 8:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2012 Time: 8:47 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-338,740	-256,130	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	209,482	10		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		22,128		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-129,258	-233,992	0	0	200.00

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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 140001

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

Worksheet S
Parts I-III
Date/Time Prepared:
11/26/2012 8:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2012 Time: 8:47 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
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   (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

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information

ECR: Date: 11/26/2012 Time: 8:47 pm
7T9OB:zkZo1S63mPeONTzaKc6o8k20
1YduV0WSnPD0TK85OOjMnh7KAdYLyJ
eLcj11Z9VZ0gsDd7

PI: Date: 11/26/2012 Time: 8:47 pm
sd05i8vuifngMnsybq6FLAIASPELP1
77gMF0X:PQeSfR2qaZGI.DjuADhSQV
juwpcjWHbg0FIkJp

(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	-338,740	-256,130	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	209,482	10		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		22,128		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-129,258	-233,992	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GRAHAM HOSPITAL HOME HEALTH AGENCY	147142	99914		06/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GRAHAM HOSPITAL HOSPICE	141558	99914		07/28/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	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 unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,735	0	0	0	151	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	07/01/2011	06/30/2012	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. 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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	0	0	410,416	118.01

		1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	Y	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
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, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 3:01 pm

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2012 3:01 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/09/2012	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: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DAN	LINHART		41.00
42.00	Enter the employer/company name of the cost report preparer.		MCGLADRY, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		563.888.4404	DAN.LINHART@MCGLADREY.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/09/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	44	16,104	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		44	16,104	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,824	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		49	17,928	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	32	11,712			19.00
20.00	NURSING FACILITY	45.00	18	6,588			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		99				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	3,900	1,175	7,493		1.00
2.00	HMO		1,086	133			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,900	1,175	7,493		7.00
8.00	INTENSIVE CARE UNIT	0	400	51	632		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		344	568		13.00
14.00	Total (see instructions)	0	4,300	1,570	8,693		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	4,079	515	6,269		19.00
20.00	NURSING FACILITY	0		4,960	6,311		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	3,019	416	4,807		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0	18,089	0	95,223		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	818		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				89		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,118	1.00
2.00	HMO					295	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	518.97	0.00	0	1,118	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	29.78	0.00			19.00
20.00	NURSING FACILITY	0.00	17.43	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	10.37	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	4.58	0.00			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0.00	68.00	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	649.13	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	471	2,508		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)	471	2,508		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC (RHC)				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part II Date/Time Prepared: 11/26/2012 3:01 pm

		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	28,968,011	0	28,968,011	1,350,192.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		1,094,315	0	1,094,315	10,800.00	3.00
4.00	Physician-Part A - Administrative		39,994	0	39,994	168.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		2,342,610	0	2,342,610	24,731.00	5.00
6.00	Non-physician-Part B		2,062,359	0	2,062,359	129,195.00	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 an 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	1,123,490	0	1,123,490	61,943.00	9.00
10.00	Excluded area salaries (see instructions)		5,026,171	3,659	5,029,830	113,439.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		37,268	0	37,268	554.75	11.00
12.00	Contract management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		5,285,939	0	5,285,939		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		181,507	0	181,507		18.00
19.00	Excluded areas		937,578	0	937,578		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		128,176	0	128,176		21.00
22.00	Physician Part A - Administrative		34,285	0	34,285		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		255,220	0	255,220		23.00
24.00	Wage-related costs (RHC/FQHC)		619,697	0	619,697		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	176,206	0	176,206	9,373.00	26.00
27.00	Administrative & General	5.00	5,172,433	0	5,172,433	277,317.00	27.00
28.00	Administrative & General under contract (see inst.)		222,989	0	222,989	1,947.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	836,921	-3,659	833,262	52,510.00	30.00
31.00	Laundry & Linen Service	8.00	19,870	0	19,870	1,999.00	31.00
32.00	Housekeeping	9.00	650,708	0	650,708	59,561.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	661,195	-369,315	291,880	25,142.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	369,315	369,315	31,812.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	505,905	0	505,905	16,337.00	38.00
39.00	Central Services and Supply	14.00	45,714	0	45,714	3,992.00	39.00
40.00	Pharmacy	15.00	606,279	0	606,279	26,049.00	40.00
41.00	Medical Records & Medical Records Library	16.00	475,461	0	475,461	36,841.00	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: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	21.45		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	101.33		3.00
4.00	Physician-Part A - Administrative	238.06		4.00
4.01	Physicians - Part A - Teaching	0.00		4.01
5.00	Physician-Part B	94.72		5.00
6.00	Non-physician-Part B	15.96		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in an approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	18.14		9.00
10.00	Excluded area salaries (see instructions)	44.34		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	67.18		11.00
12.00	Contract management and administrative services	0.00		12.00
13.00	Contract labor: Physician-Part A - Administrative	0.00		13.00
14.00	Home office salaries & wage-related costs	0.00		14.00
15.00	Home office: Physician Part A - Administrative	0.00		15.00
16.00	Home office and Contract Physicians Part A - Administrative	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 - Administrative			22.00
22.01	Physician Part A - Teaching			22.01
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	18.80		26.00
27.00	Administrative & General	18.65		27.00
28.00	Administrative & General under contract (see inst.)	114.53		28.00
29.00	Maintenance & Repairs	0.00		29.00
30.00	Operation of Plant	15.87		30.00
31.00	Laundry & Linen Service	9.94		31.00
32.00	Housekeeping	10.93		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	11.61		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	11.61		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	30.97		38.00
39.00	Central Services and Supply	11.45		39.00
40.00	Pharmacy	23.27		40.00
41.00	Medical Records & Medical Records Library	12.91		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: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part III Date/Time Prepared: 11/26/2012 3:01 pm

		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)		23,691,716	0	23,691,716	1,187,413.00	1.00
2.00	Excluded area salaries (see instructions)		6,149,661	3,659	6,153,320	175,382.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		17,542,055	-3,659	17,538,396	1,012,031.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		37,268	0	37,268	554.75	4.00
5.00	Subtotal wage-related costs (see inst.)		5,501,731	0	5,501,731	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		23,081,054	-3,659	23,077,395	1,012,585.75	6.00
7.00	Total overhead cost (see instructions)		9,373,681	-3,659	9,370,022	542,880.00	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part III | Date/Time Prepared: 11/26/2012 3:01 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	19.95		1.00
2.00	Excluded area salaries (see instructions)	35.09		2.00
3.00	Subtotal salaries (line 1 minus line 2)	17.33		3.00
4.00	Subtotal other wages & related costs (see inst.)	67.18		4.00
5.00	Subtotal wage-related costs (see inst.)	31.37		5.00
6.00	Total (sum of lines 3 thru 5)	22.79		6.00
7.00	Total overhead cost (see instructions)	17.26		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	642,971	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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	19,792	6.00
7.00	Employee Managed Care Program Administration Fees	242,810	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,530,630	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)	1,238	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)	93,170	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	361,034	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	2,047,319	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,050	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	9,696	22.00
23.00	Tuition Reimbursement	283,185	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,260,895	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	181,507	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part V Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	37,268	0	1.00
2.00	Hospital	37,268	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140001 | Component CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-4 | Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I | PPS

						1.00	
0.00	County				MCLEAN		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,191	262	951	3,404	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	159.00	19.00	69.00	247.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.50	0.00	0.50	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.63	0.00	2.63	5.00
6.00	Direct Nursing Service			3.81	0.00	3.81	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.76	0.00	0.76	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.16	0.00	0.16	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.41	0.00	0.41	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.64	0.00	1.64	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			0.09	0.00	0.09	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,561	16	98	16	1,691	21.00
22.00	Skilled Nursing Visit Charges	263,419	2,700	16,538	2,700	285,357	22.00
23.00	Physical Therapy Visits	266	6	21	5	298	23.00
24.00	Physical Therapy Visit Charges	48,811	1,101	3,854	918	54,684	24.00
25.00	Occupational Therapy Visits	69	0	2	0	71	25.00
26.00	Occupational Therapy Visit Charges	12,662	0	367	0	13,029	26.00
27.00	Speech Pathology Visits	1	0	0	0	1	27.00
28.00	Speech Pathology Visit Charges	184	0	0	0	184	28.00
29.00	Medical Social Service Visits	30	0	1	0	31	29.00
30.00	Medical Social Service Visit Charges	6,983	0	233	0	7,216	30.00
31.00	Home Health Aide Visits	287	24	3	0	314	31.00
32.00	Home Health Aide Visit Charges	30,350	2,538	317	0	33,205	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,214	46	125	21	2,406	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	362,409	6,339	21,309	3,618	393,675	35.00
36.00	Total Number of Episodes (standard/non outlier)	164		48	3	215	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	17,101	0	5,731	1,053	23,885	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-7 | Date/Time Prepared: 11/26/2012 3:01 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	49	0	49	7.00
8.00		RHL	85	0	85	8.00
9.00		RMX	63	0	63	9.00
10.00		RML	36	0	36	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	286	0	286	18.00
19.00		RHB	245	0	245	19.00
20.00		RHA	921	0	921	20.00
21.00		RMC	420	0	420	21.00
22.00		RMB	149	0	149	22.00
23.00		RMA	1,170	0	1,170	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	91	0	91	28.00
29.00		HE2	6	0	6	29.00
30.00		HE1	20	0	20	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	6	0	6	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	12	0	12	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	208	0	208	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	1	0	1	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	5	0	5	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	26	0	26	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	19	0	19	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	24	0	24	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	202	0	202	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-7 | Date/Time Prepared: 11/26/2012 3:01 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	14	0	14	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	19	0	19	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,079	0	4,079	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,123,490	48.94	N	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	1,017	0.04	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,295,520			207.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-8 | Date/Time Prepared: 11/26/2012 3:01 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	180 S MAIN STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	CANTON	IL	61520	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	FARMINGTON CLINIC	143494	14.00
14.01		CANTON CLINIC	143492	14.01
14.02		CUBA CLINIC	143497	14.02
14.03		COLEMAN CLINIC	143493	14.03
14.04				14.04

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable, and the total number of visits in column 5. (see instructions)		0	0	0	0	15.00

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

Provider CCN: 140001
Component CCN: 143493

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

Worksheet S-8

Date/Time Prepared:
11/26/2012 3:01 pm

Rural Health Clinic (RHC) I

Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/26/2012 3:01 pm
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/26/2012 3:01 pm
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL IDENTIFICATION DATA | Provider CCN: 140001 | Component CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-9 Parts I & II | Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	3,622	429	0	0	351	2.00
3.00	Inpatient Respite Care	23	0	0	0	2	3.00
4.00	General Inpatient Care	4	0	0	0	5	4.00
5.00	Total Hospice Days	3,649	429	0	0	358	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	78	5	0	0	9	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	46.78	85.80	0.00	0.00	39.78	8.00
9.00	Unduplicated Census Count	78	5	0	0	9	9.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140001 Component CCN: 141558	Period: From 07/01/2011 To 06/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 11/26/2012 3:01 pm
		Hospice I	

		Unduplicated Days Total (sum of cols. 1, 2 & 5)		
		6.00		
	PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0		1.00
2.00	Routine Home Care	4,402		2.00
3.00	Inpatient Respite Care	25		3.00
4.00	General Inpatient Care	9		4.00
5.00	Total Hospice Days	4,436		5.00
	Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	92		6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare			7.00
8.00	Average Length of Stay (line 5/line 6)	48.22		8.00
9.00	Unduplicated Census Count	92		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-10 | Date/Time Prepared: 11/26/2012 3:01 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.383829	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,016,338	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	31,966,000	6.00
7.00	Medicaid cost (line 1 times line 6)	12,269,478	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)	6,253,140	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)	6,253,140	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	4,146,439	2,814,518	6,960,957	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,591,524	1,080,294	2,671,818	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,591,524	1,080,294	2,671,818	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)	4,989,146	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	266,045	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	4,723,101	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,812,863	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	4,484,681	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,737,821	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		6,637,459	6,637,459	-2,517,823	4,119,636	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		0	0	28,388	28,388	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,499,581	2,499,581	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	176,206	7,438,097	7,614,303	151,398	7,765,701	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,172,433	5,531,951	10,704,384	-210,443	10,493,941	5.00
7.00	00700	OPERATION OF PLANT	836,921	1,804,251	2,641,172	-3,659	2,637,513	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,870	262,305	282,175	0	282,175	8.00
9.00	00900	HOUSEKEEPING	650,708	143,964	794,672	0	794,672	9.00
10.00	01000	DIETARY	661,195	706,022	1,367,217	-763,668	603,549	10.00
11.00	01100	CAFETERIA	0	0	0	763,668	763,668	11.00
13.00	01300	NURSING ADMINISTRATION	505,905	11,754	517,659	0	517,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,714	378,746	424,460	-341,235	83,225	14.00
15.00	01500	PHARMACY	606,279	89,350	695,629	0	695,629	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	475,461	242,150	717,611	0	717,611	16.00
20.00	02000	NURSING SCHOOL	910,350	199,719	1,110,069	0	1,110,069	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,577,159	216,352	2,793,511	0	2,793,511	30.00
31.00	03100	INTENSIVE CARE UNIT	475,598	30,548	506,146	0	506,146	31.00
43.00	04300	NURSERY	281,381	9,515	290,896	0	290,896	43.00
44.00	04400	SKILLED NURSING FACILITY	1,123,490	67,309	1,190,799	0	1,190,799	44.00
45.00	04500	NURSING FACILITY	562,344	46,520	608,864	0	608,864	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,656,972	3,082,284	4,739,256	-2,125,327	2,613,929	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,751	20	75,771	0	75,771	52.00
53.00	05300	ANESTHESIOLOGY	1,094,315	59,266	1,153,581	0	1,153,581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	895,680	900,766	1,796,446	0	1,796,446	54.00
57.00	05700	CT SCAN	57,094	150,740	207,834	0	207,834	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	50,192	135,363	185,555	0	185,555	58.00
60.00	06000	LABORATORY	1,639,511	1,851,245	3,490,756	0	3,490,756	60.00
65.00	06500	RESPIRATORY THERAPY	323,809	47,473	371,282	0	371,282	65.00
66.00	06600	PHYSICAL THERAPY	862,447	56,721	919,168	0	919,168	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	875,231	875,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,594,719	1,594,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,766,936	1,766,936	0	1,766,936	73.00
76.97	07697	CARDIAC REHABILITATION	254,256	41,144	295,400	0	295,400	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,728,585	7,234,693	9,963,278	-182,877	9,780,401	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,984,711	508,157	3,492,868	-3,388	3,489,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	438,782	706,953	1,145,735	30,636	1,176,371	96.00
101.00	10100	HOME HEALTH AGENCY	540,965	65,761	606,726	4,771	611,497	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	236,467	99,157	335,624	4,771	340,395	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,920,551	40,522,691	69,443,242	-195,257	69,247,985	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,460	253,329	300,789	186,536	487,325	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	8,721	8,721	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	934	934	0	934	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118-199)	28,968,011	40,776,954	69,744,965	0	69,744,965	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-94,153	4,025,483		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	28,388		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-4,311	2,495,270		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-2,332,563	5,433,138		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,522,226	8,971,715		5.00
7.00	00700	OPERATION OF PLANT	0	2,637,513		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	282,175		8.00
9.00	00900	HOUSEKEEPING	-6,576	788,096		9.00
10.00	01000	DIETARY	-33,369	570,180		10.00
11.00	01100	CAFETERIA	-428,224	335,444		11.00
13.00	01300	NURSING ADMINISTRATION	-3,691	513,968		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-196	83,029		14.00
15.00	01500	PHARMACY	-319,092	376,537		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,061	692,550		16.00
20.00	02000	NURSING SCHOOL	-664,391	445,678		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-37,750	2,755,761		30.00
31.00	03100	INTENSIVE CARE UNIT	0	506,146		31.00
43.00	04300	NURSERY	0	290,896		43.00
44.00	04400	SKILLED NURSING FACILITY	16,487	1,207,286		44.00
45.00	04500	NURSING FACILITY	9,882	618,746		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,613,929		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	75,771		52.00
53.00	05300	ANESTHESIOLOGY	-1,093,515	60,066		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-71,543	1,724,903		54.00
57.00	05700	CT SCAN	-3,759	204,075		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	185,555		58.00
60.00	06000	LABORATORY	-176,084	3,314,672		60.00
65.00	06500	RESPIRATORY THERAPY	0	371,282		65.00
66.00	06600	PHYSICAL THERAPY	0	919,168		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	875,231		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,594,719		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,766,936		73.00
76.97	07697	CARDIAC REHABILITATION	-4,760	290,640		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	-119,496	9,660,905		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-2,081,045	1,408,435		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-77,506	1,098,865		96.00
101.00	10100	HOME HEALTH AGENCY	-1,573	609,924		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	340,395		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,074,515	60,173,470		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	487,325		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	NONPAID WORKERS	0	0		193.01
193.02	19302	FOUNDATION	0	0		193.02
194.00	07950	PHYSICIANS CLINIC	0	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0		194.02
194.03	07953	RUCHFORD POB	0	8,721		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0		194.04
194.05	07955	FARMINGTON POB	0	0		194.05
194.06	07956	LEWISTON POB	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	934		194.07
194.08	07958	KELLEY HOME	0	0		194.08
200.00		TOTAL (SUM OF LINES 118-199)	-9,074,515	60,670,450		200.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/26/2012 3:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	369,315	394,353		1.00
	TOTALS		369,315	394,353		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,659	0		1.00
	TOTALS		3,659	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	30,636		1.00
2.00	RUCHFORD POB	194.03	0	8,190		2.00
3.00	HOSPICE	116.00	0	4,771		3.00
4.00		101.00	0	4,771		4.00
8.00	HOME HEALTH AGENCY					8.00
	TOTALS		0	48,368		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	58,514		1.00
2.00	RUCHFORD POB	194.03	0	531		2.00
	TOTALS		0	59,045		
	E - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	28,102		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,484,292		2.00
	TOTALS		0	2,512,394		
	F - RHC EXPENSE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	71,198	111,679		1.00
	TOTALS		71,198	111,679		
	G - EXECUTIVE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	131,398		1.00
	TOTALS		0	131,398		
	H - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	20,000		1.00
	TOTALS		0	20,000		
	I - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,594,719		1.00
	TOTALS		0	1,594,719		
	J - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	875,231		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	875,231		
500.00	Grand Total: Increases		444,172	5,747,187		500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/26/2012 3:01 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	369,315	394,353	0		1.00
	TOTALS		369,315	394,353			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	3,659	0	0		1.00
	TOTALS		3,659	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	48,368	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
8.00		0.00	0	0	0		8.00
	TOTALS		0	48,368			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	59,045	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	59,045			
	E - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,512,394	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,512,394			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC (RHC)	88.00	71,198	111,679	0		1.00
	TOTALS		71,198	111,679			
	G - EXECUTIVE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	131,398	0		1.00
	TOTALS		0	131,398			
	H - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,000	0		1.00
	TOTALS		0	20,000			
	I - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,594,719	0		1.00
	TOTALS		0	1,594,719			
	J - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	341,235	0		1.00
2.00	OPERATING ROOM	50.00	0	530,608	0		2.00
3.00	EMERGENCY	91.00	0	3,388	0		3.00
	TOTALS		0	875,231			
500.00	Grand Total: Decreases		444,172	5,747,187			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/26/2012 3:01 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,748,457	284,226	0	284,226	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	58,439,479	1,196,508	0	1,196,508	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,640,934	11,502	0	11,502	0	5.00
6.00	Movable Equipment	23,956,632	3,745,157	0	3,745,157	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100,785,502	5,237,393	0	5,237,393	0	8.00
9.00	Reconciling Items	-1,085,463	-374,346	0	-374,346	0	9.00
10.00	Total (line 8 minus line 9)	101,870,965	5,611,739	0	5,611,739	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	6,637,459	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,637,459	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	77,803,291	0	77,803,291	0.733835	42,939	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	517,815	0	517,815	0.004884	286	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	27,701,789	0	27,701,789	0.261281	15,289	2.00
3.00	Total (sum of lines 1-2)	106,022,895	0	106,022,895	1.000000	58,514	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/26/2012 3:01 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,032,683	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	59,635,987	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	14,652,436	0	5.00
6.00	Movable Equipment	27,701,789	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,022,895	0	8.00
9.00	Reconciling Items	-1,459,809	0	9.00
10.00	Total (line 8 minus line 9)	107,482,704	0	10.00

		SUMMARY OF CAPITAL		
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	6,637,459	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	6,637,459	3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	42,939	4,076,697	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	286	28,102	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	15,289	2,479,981	0	2.00
3.00	Total (sum of lines 1-2)	0	0	58,514	6,584,780	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-94,153	42,939	0	0	4,025,483	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	286	0	0	28,388	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	15,289	0	0	2,495,270	2.00
3.00	Total (sum of lines 1-2)	-94,153	58,514	0	0	6,549,141	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/26/2012 3:01 pm

	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
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	1.01
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)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,296,058			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		0		0.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	26.01
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	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-94,153	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01	TRADE, QUANTITY AND TIME DISCOUNTS	B	-10,664	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	CAFETERIA--EMPLOYEES AND GUESTS	B	-428,224	CAFETERIA	11.00	33.02
33.03			0		0.00	33.03
33.04	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-311,993	PHARMACY	15.00	33.04
33.05	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-24,661	MEDICAL RECORDS & LIBRARY	16.00	33.05
33.06			0		0.00	33.06
33.07	HME NON PATIENT SALES	B	-57,648	DURABLE MEDICAL EQUIP-RENTED	96.00	33.07
33.08	PHOTOCOPY REIMBURSE	B	-232	ADMINISTRATIVE & GENERAL	5.00	33.08
33.09	DIETARY CONSULTANT AND EMP PURCHASE	B	-30,740	DIETARY	10.00	33.09
33.10	NRSG SVS CPR CLASS FEES	B	-3,691	NURSING ADMINISTRATION	13.00	33.10
33.11			0		0.00	33.11
33.12	MISCELLANEOUS LAB REVENUE	B	-58	LABORATORY	60.00	33.12
33.13	MEDICAL STAFF DUES	B	-9,450	ADMINISTRATIVE & GENERAL	5.00	33.13
33.14	REFUND/EXP REBATE	B	-7,099	PHARMACY	15.00	33.14

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/26/2012 3:01 pm

	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	
33.15	REFUND/EXP REBATE	B	-2,629	DIETARY	10.00	33.15
33.16	HOUSKEEPING OTHER REVENUE	B	-6,576	HOUSEKEEPING	9.00	33.16
33.17	OTHER INCOME & PURCHASE GROUP	B	-120,502	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18			0		0.00	33.18
33.19	MISCELLANEOUS INCOME	B	-60	RADIOLOGY-DIAGNOSTIC	54.00	33.19
33.20	RHC OTHER INCOME	B	-119,496	RURAL HEALTH CLINIC (RHC)	88.00	33.20
33.21			0		0.00	33.21
33.22	SNF OTHER REVENUE	B	-105	SKILLED NURSING FACILITY	44.00	33.22
33.23	CARDIAC OTHER REVENUE	B	-4,760	CARDIAC REHABILITATION	76.97	33.23
33.24			0		0.00	33.24
33.25			0		0.00	33.25
33.26			0		0.00	33.26
33.27			0		0.00	33.27
33.28			0		0.00	33.28
33.29	CENT SUPP OTHER REVENUE	B	-196	CENTRAL SERVICES & SUPPLY	14.00	33.29
33.30	LABORATORY OTHER REVENUE	B	-70,095	LABORATORY	60.00	33.30
33.31	CT SCAN OTHER REVENUE	B	-3,759	CT SCAN	57.00	33.31
33.32	HME HME OTHER REVENUE	B	-19,693	DURABLE MEDICAL EQUIP-RENTED	96.00	33.32
33.33	HME HAVANA HME OTHER REVENUE	B	-165	DURABLE MEDICAL EQUIP-RENTED	96.00	33.33
33.34	HIM OTHER REVENUE	B	-400	MEDICAL RECORDS & LIBRARY	16.00	33.34
33.35	CORP COMPL OTHER REVENUE	B	-380	ADMINISTRATIVE & GENERAL	5.00	33.35
33.36	GMG LAB OTHER REVENUE	B	-151	LABORATORY	60.00	33.36
33.37	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	B	-664,391	NURSING SCHOOL	20.00	33.37
33.38	DONATIONS & DUES	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	33.38
33.39	CRNA SALARY EXPENSE	A	-1,094,315	ANESTHESIOLOGY	53.00	33.39
33.40	CRNA BENEFIT EXPENSE	A	-27,846	EMPLOYEE BENEFITS	4.00	33.40
33.41	CRNA CONTRACTED EXPENSE	A	800	ANESTHESIOLOGY	53.00	33.41
33.42	UNEMPLOYMENT CASH BASIS	A	-22,893	EMPLOYEE BENEFITS	4.00	33.42
33.43	IL PROVIDER PARTICIPATION FEE	A	17,568	SKILLED NURSING FACILITY	44.00	33.43
33.44	IL PROVIDER PARTICIPATION FEE	A	9,882	NURSING FACILITY	45.00	33.44
33.45	IL HOSPITAL PROVIDER TAX	A	-978,695	ADMINISTRATIVE & GENERAL	5.00	33.45
33.46			0		0.00	33.46
33.47	PHONE SALARIES EXPENSE	A	-5,045	ADMINISTRATIVE & GENERAL	5.00	33.47
33.48	PHONE BENEFIT EXPENSE	A	-799	EMPLOYEE BENEFITS	4.00	33.48
33.49			0		0.00	33.49
33.50	PHONE DEPREPATION M/M EXPENSE	A	-2,324	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.50
33.51	IHA & AHA DUES LOBBYING PORTION	A	-21,234	ADMINISTRATIVE & GENERAL	5.00	33.51
33.52	IL HEALTHCARE ASSOCIATION LOBBYING	A	-976	SKILLED NURSING FACILITY	44.00	33.52
33.53	IL HOMECARE COUNCIL LOBBYING	A	-1,573	HOME HEALTH AGENCY	101.00	33.53
33.54	MARKETING DEPT SALARY EXPENSE	A	-110,322	ADMINISTRATIVE & GENERAL	5.00	33.54
33.55	MARKETING DEPT BENEIFT EXPENSE	A	-11,139	EMPLOYEE BENEFITS	4.00	33.55
33.56	MARKETING DEPT OTHER EXPENSE	A	-256,467	ADMINISTRATIVE & GENERAL	5.00	33.56
33.57	MARKETING DEPRECIATION EXPENSE	A	-1,987	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.57
33.58	PHYSICIAN RECRUITMENT	A	-4,235	ADMINISTRATIVE & GENERAL	5.00	33.58
33.59	LOAN FORGIVENESS EXPENSE	A	-281,856	EMPLOYEE BENEFITS	4.00	33.59
33.60	ER PHYSICIAN BENEFITS	A	-32,623	EMPLOYEE BENEFITS	4.00	33.60
34.00	SELF INSURANCE COSTS	A	-1,955,407	EMPLOYEE BENEFITS	4.00	34.00
34.01			0		0.00	34.01
34.02			0		0.00	34.02
34.03			0		0.00	34.03
34.04			0		0.00	34.04
34.05			0		0.00	34.05
34.06			0		0.00	34.06
34.07			0		0.00	34.07
34.08			0		0.00	34.08
34.09			0		0.00	34.09
35.00			0		0.00	35.00
36.00			0		0.00	36.00
37.00			0		0.00	37.00
38.00			0		0.00	38.00
39.00			0		0.00	39.00
40.00			0		0.00	40.00
42.00			0		0.00	42.00
43.00			0		0.00	43.00
44.00			0		0.00	44.00
45.00			0		0.00	45.00
45.01			0		0.00	45.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/26/2012 3:01 pm

	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	
45.02			0		0.00	45.02
45.03			0		0.00	45.03
45.04			0		0.00	45.04
45.05			0		0.00	45.05
45.06			0		0.00	45.06
45.07			0		0.00	45.07
45.08			0		0.00	45.08
45.09			0		0.00	45.09
45.10			0		0.00	45.10
45.11			0		0.00	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,074,515			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)	0		1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB	0		26.01
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	INVST INCOME-NEW BLDGS AND FIXTURES	11		33.00
33.01	TRADE, QUANTITY AND TIME DISCOUNTS	0		33.01
33.02	CAFETERIA--EMPLOYEES AND GUESTS	0		33.02
33.03		0		33.03
33.04	SALE OF DRUGS TO OTHER THAN PATIENTS	0		33.04
33.05	SALE OF MEDICAL RECORDS & ABSTRACTS	0		33.05
33.06		0		33.06
33.07	HME NON PATIENT SALES	0		33.07
33.08	PHOTOCOPY REIMBURSE	0		33.08
33.09	DIETARY CONSULTANT AND EMP PURCHASE	0		33.09
33.10	NRSG SVS CPR CLASS FEES	0		33.10
33.11		0		33.11
33.12	MISCELLANEOUS LAB REVENUE	0		33.12
33.13	MEDICAL STAFF DUES	0		33.13
33.14	REFUND/EXP REBATE	0		33.14
33.15	REFUND/EXP REBATE	0		33.15
33.16	HOUSKEEPING OTHER REVENUE	0		33.16
33.17	OTHER INCOME & PURCHASE GROUP	0		33.17
33.18		0		33.18
33.19	MISCELLANEOUS INCOME	0		33.19
33.20	RHC OTHER INCOME	0		33.20
33.21		0		33.21
33.22	SNF OTHER REVENUE	0		33.22
33.23	CARDIAC OTHER REVENUE	0		33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00	
33.24		0	33.24
33.25		0	33.25
33.26		0	33.26
33.27		0	33.27
33.28		0	33.28
33.29	CENT SUPP OTHER REVENUE	0	33.29
33.30	LABORATORY OTHER REVENUE	0	33.30
33.31	CT SCAN OTHER REVENUE	0	33.31
33.32	HME HME OTHER REVENUE	0	33.32
33.33	HME HAVANA HME OTHER REVENUE	0	33.33
33.34	HIM OTHER REVENUE	0	33.34
33.35	CORP COMPL OTHER REVENUE	0	33.35
33.36	GMG LAB OTHER REVENUE	0	33.36
33.37	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	0	33.37
33.38	DONATIONS & DUES	0	33.38
33.39	CRNA SALARY EXPENSE	0	33.39
33.40	CRNA BENEFIT EXPENSE	0	33.40
33.41	CRNA CONTRACTED EXPENSE	0	33.41
33.42	UNEMPLOYMENT CASH BASIS	0	33.42
33.43	IL PROVIDER PARTICIPATION FEE	0	33.43
33.44	IL PROVIDER PARTICIPATION FEE	0	33.44
33.45	IL HOSPITAL PROVIDER TAX	0	33.45
33.46		0	33.46
33.47	PHONE SALARIES EXPENSE	0	33.47
33.48	PHONE BENEFIT EXPENSE	0	33.48
33.49		0	33.49
33.50	PHONE DEPREPATION M/M EXPENSE	9	33.50
33.51	IHA & AHA DUES LOBBYING PORTION	0	33.51
33.52	IL HEALTHCARE ASSOCIATION LOBBYING	0	33.52
33.53	IL HOMECARE COUNCIL LOBBYING	0	33.53
33.54	MARKETING DEPT SALARY EXPENSE	0	33.54
33.55	MARKETING DEPT BENEIFT EXPENSE	0	33.55
33.56	MARKETING DEPT OTHER EXPENSE	0	33.56
33.57	MARKETING DEPRECIATION EXPENSE	9	33.57
33.58	PHYSICIAN RECRUITMENT	0	33.58
33.59	LOAN FORGIVENESS EXPENSE	0	33.59
33.60	ER PHYSICIAN BENEFITS	0	33.60
34.00	SELF INSURANCE COSTS	0	34.00
34.01		0	34.01
34.02		0	34.02
34.03		0	34.03
34.04		0	34.04
34.05		0	34.05
34.06		0	34.06
34.07		0	34.07
34.08		9	34.08
34.09		0	34.09
35.00		0	35.00
36.00		0	36.00
37.00		9	37.00
38.00		0	38.00
39.00		0	39.00
40.00		0	40.00
42.00		0	42.00
43.00		0	43.00
44.00		0	44.00
45.00		9	45.00
45.01		0	45.01
45.02		0	45.02
45.03		0	45.03
45.04		0	45.04
45.05		0	45.05
45.06		0	45.06
45.07		0	45.07
45.08		0	45.08
45.09		0	45.09
45.10		0	45.10
45.11		0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2012 3:01 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	2,093,952	2,053,958	1.00
2.00		60.00	LABORATORY	52,250	52,250	2.00
3.00		60.00	LABORATORY	53,530	53,530	3.00
4.00		54.00	RADIOLOGY-DIAGNOSTIC	6,333	6,333	4.00
5.00		54.00	RADIOLOGY-DIAGNOSTIC	65,150	65,150	5.00
6.00		0.00		0	0	6.00
7.00		30.00	ADULTS & PEDIATRICS	37,750	37,750	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				2,308,965	2,268,971	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2012 3:01 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		39,994	159,800	168	12,907	645	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		39,994		168	12,907	645	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	12,907	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	12,907	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2012 3:01 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		27,087	2,081,045		1.00
2.00		0	52,250		2.00
3.00		0	53,530		3.00
4.00		0	6,333		4.00
5.00		0	65,150		5.00
6.00		0	0		6.00
7.00		0	37,750		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		27,087	2,296,058		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW CARDIAC REHAB	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,025,483	4,025,483				1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	28,388	0	28,388			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,495,270			2,495,270		2.00
4.00	00400	EMPLOYEE BENEFITS	5,433,138	26,133	0	1,972	5,461,243	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,971,715	421,938	0	874,880	1,076,614	5.00
7.00	00700	OPERATION OF PLANT	2,637,513	471,656	0	14,336	177,396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	282,175	47,630	0	897	4,230	8.00
9.00	00900	HOUSEKEEPING	788,096	45,721	0	7,721	138,531	9.00
10.00	01000	DIETARY	570,180	122,971	0	37,310	62,139	10.00
11.00	01100	CAFETERIA	335,444	32,880	0	0	78,625	11.00
13.00	01300	NURSING ADMINISTRATION	513,968	37,540	0	3,562	107,704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,029	0	0	2,444	9,732	14.00
15.00	01500	PHARMACY	376,537	28,113	0	52,921	129,073	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	692,550	111,351	0	22,664	101,222	16.00
20.00	02000	NURSING SCHOOL	445,678	367,182	0	21,576	193,807	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,755,761	253,341	0	116,473	548,659	30.00
31.00	03100	INTENSIVE CARE UNIT	506,146	44,192	0	8,782	101,251	31.00
43.00	04300	NURSERY	290,896	12,818	0	3,186	59,904	43.00
44.00	04400	SKILLED NURSING FACILITY	1,207,286	171,633	0	11,172	239,183	44.00
45.00	04500	NURSING FACILITY	618,746	77,321	0	11,478	119,719	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,613,929	206,718	0	342,086	352,758	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,771	37,979	0	90	16,127	52.00
53.00	05300	ANESTHESIOLOGY	60,066	14,952	0	38,479	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,724,903	129,267	0	261,262	190,684	54.00
57.00	05700	CT SCAN	204,075	0	0	169,392	12,155	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,555	35,192	0	132,629	10,686	58.00
60.00	06000	LABORATORY	3,314,672	186,253	0	75,346	349,040	60.00
65.00	06500	RESPIRATORY THERAPY	371,282	2,300	0	13,124	68,937	65.00
66.00	06600	PHYSICAL THERAPY	919,168	51,543	0	4,465	183,609	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	875,231	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,594,719	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,936	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	290,640	0	28,388	13,054	54,129	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	9,660,905	586,896	0	84,927	565,739	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,408,435	155,045	0	97,657	224,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,098,865	0	0	26,103	93,414	96.00
101.00	10100	HOME HEALTH AGENCY	609,924	0	0	28,974	115,168	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	340,395	0	0	8,370	50,342	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,173,470	3,678,565	28,388	2,487,332	5,435,203	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,300	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	487,325	168,965	0	7,938	26,040	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	32,655	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	54,602	0	0	0	194.02
194.03	07953	RUCHFORD POB	8,721	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	76,396	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	934	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	60,670,450	4,025,483	28,388	2,495,270	5,461,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,345,147	11,345,147				5.00
7.00	00700	OPERATION OF PLANT	3,300,901	759,230	4,060,131			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334,932	77,037	62,267	474,236		8.00
9.00	00900	HOUSEKEEPING	980,069	225,423	59,771	12,310	1,277,573	9.00
10.00	01000	DIETARY	792,600	182,304	160,759	0	33,373	10.00
11.00	01100	CAFETERIA	446,949	102,801	42,984	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	662,774	152,443	49,076	0	10,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,205	21,898	0	0	0	14.00
15.00	01500	PHARMACY	586,644	134,932	36,752	0	11,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	927,787	213,398	145,568	0	0	16.00
20.00	02000	NURSING SCHOOL	1,028,243	236,503	480,014	1,229	37,232	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,674,234	845,100	331,191	138,980	393,837	30.00
31.00	03100	INTENSIVE CARE UNIT	660,371	151,890	57,772	12,961	0	31.00
43.00	04300	NURSERY	366,804	84,367	16,756	3,058	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,629,274	374,744	224,374	86,973	214,918	44.00
45.00	04500	NURSING FACILITY	827,264	190,277	101,081	53,098	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,515,491	808,588	270,241	75,539	236,119	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,967	29,893	49,649	0	0	52.00
53.00	05300	ANESTHESIOLOGY	113,497	26,105	19,547	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,306,116	530,423	168,990	17,753	45,267	54.00
57.00	05700	CT SCAN	385,622	88,696	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	364,062	83,737	46,006	4,619	0	58.00
60.00	06000	LABORATORY	3,925,311	902,849	243,487	868	37,789	60.00
65.00	06500	RESPIRATORY THERAPY	455,643	104,801	3,007	0	9,825	65.00
66.00	06600	PHYSICAL THERAPY	1,158,785	266,529	67,382	8,606	26,014	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	875,231	201,309	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,594,719	366,797	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,936	406,408	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	386,211	88,831	0	0	42,920	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	10,898,467	2,506,704	767,245	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,885,763	433,739	202,689	57,127	134,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,218,382	280,236	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	754,066	173,440	0	0	8,274	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	399,107	91,797	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,792,574	11,143,229	3,606,608	473,121	1,242,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,300	3,289	18,694	0	6,404	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	690,268	158,766	220,887	1,115	28,719	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	32,655	7,511	42,689	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	54,602	12,559	71,381	0	0	194.02
194.03	07953	RUCHFORD POB	8,721	2,006	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	76,396	17,572	99,872	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	934	215	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	60,670,450	11,345,147	4,060,131	474,236	1,277,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,169,036					10.00
11.00	01100	CAFETERIA	0	592,734				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,275	889,109			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,491	0	120,594		14.00
15.00	01500	PHARMACY	0	22,767	0	1,378	794,366	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,204	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	30,677	0	114	37	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	453,320	95,357	700,494	1,240	1,116	30.00
31.00	03100	INTENSIVE CARE UNIT	34,436	14,056	103,257	221	52	31.00
43.00	04300	NURSERY	0	8,965	65,855	237	8	43.00
44.00	04400	SKILLED NURSING FACILITY	339,665	54,153	0	623	135	44.00
45.00	04500	NURSING FACILITY	341,615	31,695	0	184	28	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,008	0	20,290	7,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,655	19,503	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	9,438	0	72	45	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,950	0	383	30,864	54.00
57.00	05700	CT SCAN	0	1,891	0	111	13	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,855	0	12	0	58.00
60.00	06000	LABORATORY	0	77,738	0	969	310	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,693	0	578	615	65.00
66.00	06600	PHYSICAL THERAPY	0	27,658	0	154	29	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	31,975	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	57,867	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	587,944	73.00
76.97	07697	CARDIAC REHABILITATION	0	10,583	0	94	201	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	2,336	127,825	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	47,625	0	1,165	2,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	2,710	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	573	168	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	32,131	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,169,036	592,734	889,109	120,576	794,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	18	107	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,169,036	592,734	889,109	120,594	794,366	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,318,957					16.00
20.00	02000	NURSING SCHOOL	0	1,814,049				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	365,201	951,127	7,951,197	0	7,951,197	30.00
31.00	03100	INTENSIVE CARE UNIT	24,231	66,125	1,125,372	0	1,125,372	31.00
43.00	04300	NURSERY	15,640	0	561,690	0	561,690	43.00
44.00	04400	SKILLED NURSING FACILITY	47,305	316,942	3,289,106	0	3,289,106	44.00
45.00	04500	NURSING FACILITY	47,576	2,624	1,595,442	0	1,595,442	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,631	152,661	5,293,521	0	5,293,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	231,667	0	231,667	52.00
53.00	05300	ANESTHESIOLOGY	0	0	168,704	0	168,704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	317,248	20,242	3,472,236	0	3,472,236	54.00
57.00	05700	CT SCAN	0	0	476,333	0	476,333	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	500,291	0	500,291	58.00
60.00	06000	LABORATORY	117,163	0	5,306,484	0	5,306,484	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	588,162	0	588,162	65.00
66.00	06600	PHYSICAL THERAPY	0	14,619	1,569,776	0	1,569,776	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,108,515	0	1,108,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	2,019,383	0	2,019,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,761,288	0	2,761,288	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,741	553,581	0	553,581	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	68,974	14,371,551	0	14,371,551	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	234,962	65,375	3,064,968	0	3,064,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,501,328	0	1,501,328	96.00
101.00	10100	HOME HEALTH AGENCY	0	51,599	988,120	0	988,120	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	17,993	541,028	0	541,028	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,318,957	1,753,022	59,039,743	0	59,039,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	42,687	0	42,687	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	61,027	1,160,907	0	1,160,907	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	82,855	0	82,855	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	138,542	0	138,542	194.02
194.03	07953	RUCHFORD POB	0	0	10,727	0	10,727	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	193,840	0	193,840	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	1,149	0	1,149	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,318,957	1,814,049	60,670,450	0	60,670,450	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	26,133	0	1,972	28,105	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	421,938	0	874,880	1,296,818	5.00
7.00	00700	OPERATION OF PLANT	399	471,656	0	14,336	486,391	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,630	0	897	48,527	8.00
9.00	00900	HOUSEKEEPING	0	45,721	0	7,721	53,442	9.00
10.00	01000	DIETARY	0	122,971	0	37,310	160,281	10.00
11.00	01100	CAFETERIA	0	32,880	0	0	32,880	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,540	0	3,562	41,102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,444	2,444	14.00
15.00	01500	PHARMACY	0	28,113	0	52,921	81,034	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	111,351	0	22,664	134,015	16.00
20.00	02000	NURSING SCHOOL	0	367,182	0	21,576	388,758	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	253,341	0	116,473	369,814	30.00
31.00	03100	INTENSIVE CARE UNIT	0	44,192	0	8,782	52,974	31.00
43.00	04300	NURSERY	0	12,818	0	3,186	16,004	43.00
44.00	04400	SKILLED NURSING FACILITY	0	171,633	0	11,172	182,805	44.00
45.00	04500	NURSING FACILITY	0	77,321	0	11,478	88,799	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	206,718	0	342,086	548,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,979	0	90	38,069	52.00
53.00	05300	ANESTHESIOLOGY	1,234	14,952	0	38,479	54,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,267	0	261,262	390,529	54.00
57.00	05700	CT SCAN	0	0	0	169,392	169,392	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	35,192	0	132,629	167,821	58.00
60.00	06000	LABORATORY	0	186,253	0	75,346	261,599	60.00
65.00	06500	RESPIRATORY THERAPY	2,208	2,300	0	13,124	17,632	65.00
66.00	06600	PHYSICAL THERAPY	0	51,543	0	4,465	56,008	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	28,388	13,054	41,442	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	586,896	0	84,927	671,823	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	155,045	0	97,657	252,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	30,636	0	0	26,103	56,739	96.00
101.00	10100	HOME HEALTH AGENCY	4,771	0	0	28,974	33,745	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	58,940	0	0	8,370	67,310	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,188	3,678,565	28,388	2,487,332	6,292,473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,300	0	0	14,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	168,965	0	7,938	176,903	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	32,655	0	0	32,655	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	54,602	0	0	54,602	194.02
194.03	07953	RUCHFORD POB	8,190	0	0	0	8,190	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	76,396	0	0	76,396	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	106,378	4,025,483	28,388	2,495,270	6,655,519	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	28,105					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,534	1,302,352				5.00
7.00	00700	OPERATION OF PLANT	913	87,154	574,458			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22	8,843	8,810	66,202		8.00
9.00	00900	HOUSEKEEPING	713	25,877	8,457	1,718	90,207	9.00
10.00	01000	DIETARY	320	20,927	22,745	0	2,356	10.00
11.00	01100	CAFETERIA	405	11,801	6,082	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	554	17,499	6,944	0	744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50	2,514	0	0	0	14.00
15.00	01500	PHARMACY	664	15,489	5,200	0	840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	521	24,496	20,596	0	0	16.00
20.00	02000	NURSING SCHOOL	998	27,149	67,916	172	2,629	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,825	97,011	46,859	19,402	27,809	30.00
31.00	03100	INTENSIVE CARE UNIT	521	17,436	8,174	1,809	0	31.00
43.00	04300	NURSERY	308	9,685	2,371	427	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,231	43,018	31,746	12,141	15,175	44.00
45.00	04500	NURSING FACILITY	616	21,842	14,302	7,412	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,816	92,820	38,236	10,545	16,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83	3,432	7,025	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,997	2,766	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982	60,888	23,910	2,478	3,196	54.00
57.00	05700	CT SCAN	63	10,182	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	55	9,612	6,509	645	0	58.00
60.00	06000	LABORATORY	1,797	103,640	34,450	121	2,668	60.00
65.00	06500	RESPIRATORY THERAPY	355	12,030	425	0	694	65.00
66.00	06600	PHYSICAL THERAPY	945	30,595	9,534	1,201	1,837	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,109	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	42,105	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46,652	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	279	10,197	0	0	3,030	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,912	287,766	108,554	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,156	49,790	28,678	7,975	9,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	481	32,169	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	593	19,910	0	0	584	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	259	10,538	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,971	1,279,173	510,289	66,046	87,727	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	378	2,645	0	452	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	134	18,225	31,253	156	2,028	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	862	6,040	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	1,442	10,100	0	0	194.02
194.03	07953	RUCHFORD POB	0	230	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	2,017	14,131	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	25	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,105	1,302,352	574,458	66,202	90,207	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	206,629					10.00
11.00	01100	CAFETERIA	0	51,168				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,232	68,075			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	301	0	5,309		14.00
15.00	01500	PHARMACY	0	1,965	0	61	105,253	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,780	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	2,648	0	5	5	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,125	8,233	53,634	55	148	30.00
31.00	03100	INTENSIVE CARE UNIT	6,087	1,213	7,906	10	7	31.00
43.00	04300	NURSERY	0	774	5,042	10	1	43.00
44.00	04400	SKILLED NURSING FACILITY	60,036	4,675	0	27	18	44.00
45.00	04500	NURSING FACILITY	60,381	2,736	0	8	4	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,921	0	893	1,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	229	1,493	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	815	0	3	6	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,017	0	17	4,089	54.00
57.00	05700	CT SCAN	0	163	0	5	2	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	160	0	1	0	58.00
60.00	06000	LABORATORY	0	6,711	0	43	41	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,182	0	25	82	65.00
66.00	06600	PHYSICAL THERAPY	0	2,388	0	7	4	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,407	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,548	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	77,901	73.00
76.97	07697	CARDIAC REHABILITATION	0	914	0	4	27	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	103	16,937	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,111	0	51	275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	359	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	25	22	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	4,257	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	206,629	51,168	68,075	5,308	105,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1	14	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	206,629	51,168	68,075	5,309	105,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	182,408					16.00
20.00	02000	NURSING SCHOOL	0	490,280				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,505		756,420	0	756,420	30.00
31.00	03100	INTENSIVE CARE UNIT	3,351		99,488	0	99,488	31.00
43.00	04300	NURSERY	2,163		36,785	0	36,785	43.00
44.00	04400	SKILLED NURSING FACILITY	6,542		357,414	0	357,414	44.00
45.00	04500	NURSING FACILITY	6,580		202,680	0	202,680	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,694		736,455	0	736,455	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		50,331	0	50,331	52.00
53.00	05300	ANESTHESIOLOGY	0		61,252	0	61,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,875		532,981	0	532,981	54.00
57.00	05700	CT SCAN	0		179,807	0	179,807	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		184,803	0	184,803	58.00
60.00	06000	LABORATORY	16,203		427,273	0	427,273	60.00
65.00	06500	RESPIRATORY THERAPY	0		32,425	0	32,425	65.00
66.00	06600	PHYSICAL THERAPY	0		102,519	0	102,519	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		24,516	0	24,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		44,653	0	44,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		124,553	0	124,553	73.00
76.97	07697	CARDIAC REHABILITATION	0		55,893	0	55,893	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0		1,088,095	0	1,088,095	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	32,495		386,726	0	386,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		89,748	0	89,748	96.00
101.00	10100	HOME HEALTH AGENCY	0		54,879	0	54,879	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		82,364	0	82,364	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	182,408	0	5,712,060	0	5,712,060	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		17,775	0	17,775	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		228,714	0	228,714	192.00
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
193.01	19301	NONPAID WORKERS	0		0	0	0	193.01
193.02	19302	FOUNDATION	0		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0		39,557	0	39,557	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0		66,144	0	66,144	194.02
194.03	07953	RUCHFORD POB	0		8,420	0	8,420	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		92,544	0	92,544	194.04
194.05	07955	FARMINGTON POB	0		0	0	0	194.05
194.06	07956	LEWISTON POB	0		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0		25	0	25	194.07
194.08	07958	KELLEY HOME	0		0	0	0	194.08
200.00		Cross Foot Adjustments		490,280	490,280	0	490,280	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	182,408	490,280	6,655,519	0	6,655,519	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	339,497					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,484,295			2.00
4.00	00400	EMPLOYEE BENEFITS	2,204	0	1,963	25,652,524		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,585	0	871,033	5,057,066	-11,345,147	5.00
7.00	00700	OPERATION OF PLANT	39,778	0	14,273	833,262	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	0	893	19,870	0	8.00
9.00	00900	HOUSEKEEPING	3,856	0	7,687	650,708	0	9.00
10.00	01000	DIETARY	10,371	0	37,146	291,880	0	10.00
11.00	01100	CAFETERIA	2,773	0	0	369,315	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,166	0	3,546	505,905	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,433	45,714	0	14.00
15.00	01500	PHARMACY	2,371	0	52,688	606,279	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,391	0	22,564	475,461	0	16.00
20.00	02000	NURSING SCHOOL	30,967	0	21,481	910,350	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,366	0	115,961	2,577,159	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,727	0	8,743	475,598	0	31.00
43.00	04300	NURSERY	1,081	0	3,172	281,381	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,475	0	11,123	1,123,490	0	44.00
45.00	04500	NURSING FACILITY	6,521	0	11,428	562,344	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,434	0	340,581	1,656,972	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,203	0	90	75,751	0	52.00
53.00	05300	ANESTHESIOLOGY	1,261	0	38,310	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,902	0	260,113	895,680	0	54.00
57.00	05700	CT SCAN	0	0	168,647	57,094	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,968	0	132,046	50,192	0	58.00
60.00	06000	LABORATORY	15,708	0	75,015	1,639,511	0	60.00
65.00	06500	RESPIRATORY THERAPY	194	0	13,066	323,809	0	65.00
66.00	06600	PHYSICAL THERAPY	4,347	0	4,445	862,447	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	30,653	12,997	254,256	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	49,497	0	84,553	2,657,387	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,076	0	97,227	1,055,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	25,988	438,782	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	28,847	540,965	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	8,333	236,467	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,239	30,653	2,476,392	25,530,207	-11,345,147	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,206	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,250	0	7,903	122,317	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,754	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	4,605	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,443	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,025,483	28,388	2,495,270	5,461,243		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.857198	0.926108	1.004418	0.212893		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				28,105		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001096		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	49,325,303					5.00
7.00	00700	OPERATION OF PLANT	3,300,901	261,930				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334,932	4,017	1,073,070			8.00
9.00	00900	HOUSEKEEPING	980,069	3,856	27,854	32,118		9.00
10.00	01000	DIETARY	792,600	10,371	0	839	64,739	10.00
11.00	01100	CAFETERIA	446,949	2,773	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	662,774	3,166	0	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,205	0	0	0	0	14.00
15.00	01500	PHARMACY	586,644	2,371	0	299	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	927,787	9,391	0	0	0	16.00
20.00	02000	NURSING SCHOOL	1,028,243	30,967	2,782	936	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,674,234	21,366	314,475	9,901	25,104	30.00
31.00	03100	INTENSIVE CARE UNIT	660,371	3,727	29,328	0	1,907	31.00
43.00	04300	NURSERY	366,804	1,081	6,919	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,629,274	14,475	196,797	5,403	18,810	44.00
45.00	04500	NURSING FACILITY	827,264	6,521	120,146	0	18,918	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,515,491	17,434	170,924	5,936	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,967	3,203	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	113,497	1,261	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,306,116	10,902	40,170	1,138	0	54.00
57.00	05700	CT SCAN	385,622	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	364,062	2,968	10,452	0	0	58.00
60.00	06000	LABORATORY	3,925,311	15,708	1,963	950	0	60.00
65.00	06500	RESPIRATORY THERAPY	455,643	194	0	247	0	65.00
66.00	06600	PHYSICAL THERAPY	1,158,785	4,347	19,474	654	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	875,231	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,594,719	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,936	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	386,211	0	0	1,079	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	10,898,467	49,497	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,885,763	13,076	129,264	3,380	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,218,382	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	754,066	0	0	208	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	399,107	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,447,427	232,672	1,070,548	31,235	64,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,300	1,206	0	161	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	690,268	14,250	2,522	722	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	32,655	2,754	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	54,602	4,605	0	0	0	194.02
194.03	07953	RUCHFORD POB	8,721	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	76,396	6,443	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	934	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,345,147	4,060,131	474,236	1,277,573	1,169,036	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.230007	15.500825	0.441943	39.777477	18.057678	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,302,352	574,458	66,202	90,207	206,629	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.026403	2.193174	0.061694	2.808612	3.191724	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	32,596					11.00
13.00	01300	NURSING ADMINISTRATION	785	6,656				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	192	0	3,323,402			14.00
15.00	01500	PHARMACY	1,252	0	37,978	2,313,402		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,771	0	0	0	126,500	16.00
20.00	02000	NURSING SCHOOL	1,687	0	3,151	109	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,244	5,244	34,161	3,249	35,026	30.00
31.00	03100	INTENSIVE CARE UNIT	773	773	6,100	151	2,324	31.00
43.00	04300	NURSERY	493	493	6,537	23	1,500	43.00
44.00	04400	SKILLED NURSING FACILITY	2,978	0	17,177	392	4,537	44.00
45.00	04500	NURSING FACILITY	1,743	0	5,083	82	4,563	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,135	0	559,174	23,162	14,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	146	146	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	519	0	1,974	131	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,922	0	10,562	89,884	30,427	54.00
57.00	05700	CT SCAN	104	0	3,057	39	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	102	0	338	0	0	58.00
60.00	06000	LABORATORY	4,275	0	26,700	903	11,237	60.00
65.00	06500	RESPIRATORY THERAPY	753	0	15,925	1,792	0	65.00
66.00	06600	PHYSICAL THERAPY	1,521	0	4,248	83	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	881,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,594,719	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,712,249	0	73.00
76.97	07697	CARDIAC REHABILITATION	582	0	2,584	584	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	64,364	372,261	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,619	0	32,110	6,042	22,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	7,892	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	15,795	489	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	93,574	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,596	6,656	3,322,918	2,313,091	126,500	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	484	311	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	592,734	889,109	120,594	794,366	1,318,957	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.184256	133.580078	0.036286	0.343376	10.426538	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,168	68,075	5,309	105,253	182,408	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1.569763	10.227614	0.001597	0.045497	1.441960	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	
			20.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING SCHOOL	967,860	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	507,460	30.00
31.00	03100	INTENSIVE CARE UNIT	35,280	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	169,100	44.00
45.00	04500	NURSING FACILITY	1,400	45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	81,450	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,800	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	7,800	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.97	07697	CARDIAC REHABILITATION	13,200	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)	36,800	88.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	34,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	96.00
101.00	10100	HOME HEALTH AGENCY	27,530	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	9,600	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	935,300	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,560	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	NONPAID WORKERS	0	193.01
193.02	19302	FOUNDATION	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	194.02
194.03	07953	RUCHFORD POB	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	194.04
194.05	07955	FARMINGTON POB	0	194.05
194.06	07956	LEWISTON POB	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	194.07
194.08	07958	KELLEY HOME	0	194.08
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,814,049	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.874289	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	490,280	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.506561	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/26/2012 3:01 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,951,197		7,951,197	0	7,951,197	30.00
31.00	03100	INTENSIVE CARE UNIT	1,125,372		1,125,372	0	1,125,372	31.00
43.00	04300	NURSERY	561,690		561,690	0	561,690	43.00
44.00	04400	SKILLED NURSING FACILITY	3,289,106		3,289,106	0	3,289,106	44.00
45.00	04500	NURSING FACILITY	1,595,442		1,595,442	0	1,595,442	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,293,521		5,293,521	0	5,293,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	231,667		231,667	0	231,667	52.00
53.00	05300	ANESTHESIOLOGY	168,704		168,704	0	168,704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,472,236		3,472,236	0	3,472,236	54.00
57.00	05700	CT SCAN	476,333		476,333	0	476,333	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	500,291		500,291	0	500,291	58.00
60.00	06000	LABORATORY	5,306,484		5,306,484	0	5,306,484	60.00
65.00	06500	RESPIRATORY THERAPY	588,162	0	588,162	0	588,162	65.00
66.00	06600	PHYSICAL THERAPY	1,569,776	0	1,569,776	0	1,569,776	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,108,515		1,108,515	0	1,108,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,019,383		2,019,383	0	2,019,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,761,288		2,761,288	0	2,761,288	73.00
76.97	07697	CARDIAC REHABILITATION	553,581		553,581	0	553,581	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	14,371,551		14,371,551	0	14,371,551	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,064,968		3,064,968	27,087	3,092,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	782,589		782,589		782,589	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,501,328		1,501,328	0	1,501,328	96.00
101.00	10100	HOME HEALTH AGENCY	988,120		988,120		988,120	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	541,028		541,028		541,028	116.00
200.00		Subtotal (see instructions)	59,822,332	0	59,822,332	27,087	59,849,419	200.00
201.00		Less Observation Beds	782,589		782,589		782,589	201.00
202.00		Total (see instructions)	59,039,743	0	59,039,743	27,087	59,066,830	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/26/2012 3:01 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,160,355		8,160,355			30.00
31.00	03100	INTENSIVE CARE UNIT	1,241,686		1,241,686			31.00
43.00	04300	NURSERY	325,539		325,539			43.00
44.00	04400	SKILLED NURSING FACILITY	2,295,520		2,295,520			44.00
45.00	04500	NURSING FACILITY	1,062,323		1,062,323			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,059,603	10,436,121	16,495,724	0.320903	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446,504	127,285	573,789	0.403749	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,637,772	915,166	2,552,938	0.066082	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,781,307	16,055,312	17,836,619	0.194669	0.000000	54.00
57.00	05700	CT SCAN	1,258,621	7,639,405	8,898,026	0.053532	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	332,985	5,619,965	5,952,950	0.084041	0.000000	58.00
60.00	06000	LABORATORY	4,722,928	19,006,964	23,729,892	0.223620	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,750,922	402,142	4,153,064	0.141621	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,517,760	1,904,748	3,422,508	0.458662	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,113,476	2,572,261	4,685,737	0.236572	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,264,987	635,692	2,900,679	0.696176	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,686,204	2,872,535	8,558,739	0.322628	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	514,519	514,519	1.075919	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	19,376,100	19,376,100			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	4,625,675	12,714,641	17,340,316	0.176754	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	225,757	630,085	855,842	0.914408	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,958,580	2,958,580	0.507449	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	845,884	845,884			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,119,280	1,119,280			116.00
200.00		Subtotal (see instructions)	49,509,924	106,346,685	155,856,609			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,509,924	106,346,685	155,856,609			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/26/2012 3:01 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.320903	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.403749	52.00
53.00	05300	ANESTHESIOLOGY	0.066082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194669	54.00
57.00	05700	CT SCAN	0.053532	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084041	58.00
60.00	06000	LABORATORY	0.223620	60.00
65.00	06500	RESPIRATORY THERAPY	0.141621	65.00
66.00	06600	PHYSICAL THERAPY	0.458662	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.696176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322628	73.00
76.97	07697	CARDIAC REHABILITATION	1.075919	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC (RHC)		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.178316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914408	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.507449	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	756,420	0	756,420	8,311	91.01	30.00
31.00	03100	INTENSIVE CARE UNIT	99,488		99,488	632	157.42	31.00
43.00	04300	NURSERY	36,785		36,785	568	64.76	43.00
44.00	04400	SKILLED NURSING FACILITY	357,414		357,414	6,269	57.01	44.00
45.00	04500	NURSING FACILITY	202,680		202,680	6,311	32.12	45.00
200.00		Total (lines 30-199)	1,452,787		1,452,787	22,091		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 11/26/2012 3:01 pm

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		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	03000	ADULTS & PEDIATRICS	3,900	354,939		30.00
31.00	03100	INTENSIVE CARE UNIT	400	62,968		31.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,079	232,544		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	8,379	650,451		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	736,455	16,495,724	0.044645	2,742,130	122,422	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,331	573,789	0.087717	6,000	526	52.00
53.00	05300	ANESTHESIOLOGY	61,252	2,552,938	0.023993	280,607	6,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	532,981	17,836,619	0.029881	1,060,781	31,697	54.00
57.00	05700	CT SCAN	179,807	8,898,026	0.020208	744,202	15,039	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	184,803	5,952,950	0.031044	182,676	5,671	58.00
60.00	06000	LABORATORY	427,273	23,729,892	0.018006	2,913,168	52,455	60.00
65.00	06500	RESPIRATORY THERAPY	32,425	4,153,064	0.007807	611,508	4,774	65.00
66.00	06600	PHYSICAL THERAPY	102,519	3,422,508	0.029954	231,920	6,947	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,516	4,685,737	0.005232	1,431,251	7,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	44,653	2,900,679	0.015394	1,229,801	18,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,553	8,558,739	0.014553	2,420,171	35,221	73.00
76.97	07697	CARDIAC REHABILITATION	55,893	514,519	0.108632	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	1,088,095	19,376,100	0.056157	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	386,726	17,340,316	0.022302	1,727,028	38,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,450	855,842	0.086990	149,072	12,968	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	89,748	2,958,580	0.030335	0	0	96.00
200.00		Total (lines 50-199)	4,196,480	140,806,022		15,730,315	359,389	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	951,127	0	0	0	951,127	30.00
31.00	03100	INTENSIVE CARE UNIT	66,125	0	0		66,125	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	316,942	0	0		316,942	44.00
45.00	04500	NURSING FACILITY	2,624	0	0		2,624	45.00
200.00		Total (lines 30-199)	1,336,818	0	0		1,336,818	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/26/2012 3:01 pm

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		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	03000	ADULTS & PEDIATRICS	8,311	114.44	3,900	446,316	0	30.00
31.00	03100	INTENSIVE CARE UNIT	632	104.63	400	41,852	0	31.00
43.00	04300	NURSERY	568	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,269	50.56	4,079	206,234	0	44.00
45.00	04500	NURSING FACILITY	6,311	0.42	0	0	0	45.00
200.00		Total (lines 30-199)	22,091		8,379	694,402	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	152,661	0	0	152,661	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,242	0	0	20,242	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,619	0	0	14,619	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,741	0	0	24,741	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	68,974	0	0	68,974	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	65,375	0	0	65,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	93,614	0	0	93,614	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	440,226	0	0	440,226	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/26/2012 3:01 pm

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		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	05000	OPERATING ROOM	152,661	16,495,724	0.009255	0.009255	2,742,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	573,789	0.000000	0.000000	6,000	52.00
53.00	05300	ANESTHESIOLOGY	0	2,552,938	0.000000	0.000000	280,607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,242	17,836,619	0.001135	0.001135	1,060,781	54.00
57.00	05700	CT SCAN	0	8,898,026	0.000000	0.000000	744,202	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,952,950	0.000000	0.000000	182,676	58.00
60.00	06000	LABORATORY	0	23,729,892	0.000000	0.000000	2,913,168	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,153,064	0.000000	0.000000	611,508	65.00
66.00	06600	PHYSICAL THERAPY	14,619	3,422,508	0.004271	0.004271	231,920	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,685,737	0.000000	0.000000	1,431,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,900,679	0.000000	0.000000	1,229,801	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,558,739	0.000000	0.000000	2,420,171	73.00
76.97	07697	CARDIAC REHABILITATION	24,741	514,519	0.048086	0.048086	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	68,974	19,376,100	0.003560	0.003560	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	65,375	17,340,316	0.003770	0.003770	1,727,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	93,614	855,842	0.109382	0.109382	149,072	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,958,580	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	440,226	140,806,022			15,730,315	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	05000	OPERATING ROOM	25,378	2,978,077	27,562	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	307,633	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,204	4,488,503	5,094	0	0	54.00
57.00	05700	CT SCAN	0	2,478,581	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,433,263	0	0	0	58.00
60.00	06000	LABORATORY	0	1,417,658	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	114,959	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	991	12,359	53	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	371,406	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	189,837	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	661,346	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	237,791	11,434	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,511	2,903,076	10,945	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,306	185,637	20,305	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	50,390	17,780,126	75,393	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/26/2012 3:01 pm

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		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.320903	2,978,077	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.403749	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.066082	307,633	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194669	4,488,503	0	0		54.00
57.00	05700	CT SCAN	0.053532	2,478,581	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084041	1,433,263	0	0		58.00
60.00	06000	LABORATORY	0.223620	1,417,658	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.141621	114,959	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.458662	12,359	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236572	371,406	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.696176	189,837	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322628	661,346	0	10,577		73.00
76.97	07697	CARDIAC REHABILITATION	1.075919	237,791	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000					88.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.176754	2,903,076	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914408	185,637	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.507449	0	0	0		96.00
200.00		Subtotal (see instructions)		17,780,126	0	10,577		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		17,780,126	0	10,577		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	955,674	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	20,329	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	873,772	0	0		54.00
57.00	05700	CT SCAN	132,683	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	120,453	0	0		58.00
60.00	06000	LABORATORY	317,017	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	16,281	0	0		65.00
66.00	06600	PHYSICAL THERAPY	5,669	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,864	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	132,160	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,369	0	3,412		73.00
76.97	07697	CARDIAC REHABILITATION	255,844	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	513,130	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	169,748	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Subtotal (see instructions)	3,813,993	0	3,412		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,813,993	0	3,412		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	152,661	0	0	152,661	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,242	0	0	20,242	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,619	0	0	14,619	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,741	0	0	24,741	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	68,974	0	0	68,974	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	65,375	0	0	65,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	93,614	0	0	93,614	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	440,226	0	0	440,226	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,661	16,495,724	0.009255	0.009255	10,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	573,789	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,552,938	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,242	17,836,619	0.001135	0.001135	8,521	54.00
57.00	05700	CT SCAN	0	8,898,026	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,952,950	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	23,729,892	0.000000	0.000000	27,017	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,153,064	0.000000	0.000000	251,046	65.00
66.00	06600	PHYSICAL THERAPY	14,619	3,422,508	0.004271	0.004271	735,920	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,685,737	0.000000	0.000000	642,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,900,679	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,558,739	0.000000	0.000000	416,224	73.00
76.97	07697	CARDIAC REHABILITATION	24,741	514,519	0.048086	0.048086	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	68,974	19,376,100	0.003560	0.003560	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	65,375	17,340,316	0.003770	0.003770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	93,614	855,842	0.109382	0.109382	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,958,580	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	440,226	140,806,022			2,091,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,143	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	3,248	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.320903	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.403749	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.066082	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194669	0	0	0		54.00
57.00	05700	CT SCAN	0.053532	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084041	0	0	0		58.00
60.00	06000	LABORATORY	0.223620	0	15	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.141621	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.458662	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236572	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.696176	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322628	0	49	921		73.00
76.97	07697	CARDIAC REHABILITATION	1.075919	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000					88.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.176754	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914408	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.507449	0	0	0		96.00
200.00		Subtotal (see instructions)		0	64	921		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	64	921		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	3	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16	297		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Subtotal (see instructions)	0	19	297		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	19	297		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,311	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,311	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,493	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,900	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,951,197	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,951,197	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	9,044,795	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	9,044,795	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.879091	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,207.10	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,951,197	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)	956.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,731,169	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,731,169	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,125,372	632	1,780.65	400	712,260	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,426,870	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,870,299	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)	906,075	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	409,779	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,315,854	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,554,445	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)	818	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	956.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	782,589	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	756,420	7,951,197	0.095133	782,589	74,450	90.00
91.00	Nursing School cost	951,127	7,951,197	0.119621	782,589	93,614	91.00
92.00	Allied health cost	0	7,951,197	0.000000	782,589	0	92.00
93.00	All other Medical Education	0	7,951,197	0.000000	782,589	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,269	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,269	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,079	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,289,106	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,289,106	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,295,520	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,295,520	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.432837	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)	366.17	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,289,106	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,289,106	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	524.66	71.00
72.00	Program routine service cost (line 9 x line 71)	2,140,088	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,140,088	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,140,088	83.00
84.00	Program inpatient ancillary services (see instructions)	670,299	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,810,387	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,804,417		30.00
31.00	03100	INTENSIVE CARE UNIT		655,062		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.320903	2,742,130	879,958	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.403749	6,000	2,422	52.00
53.00	05300	ANESTHESIOLOGY	0.066082	280,607	18,543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194669	1,060,781	206,501	54.00
57.00	05700	CT SCAN	0.053532	744,202	39,839	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084041	182,676	15,352	58.00
60.00	06000	LABORATORY	0.223620	2,913,168	651,443	60.00
65.00	06500	RESPIRATORY THERAPY	0.141621	611,508	86,602	65.00
66.00	06600	PHYSICAL THERAPY	0.458662	231,920	106,373	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236572	1,431,251	338,594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.696176	1,229,801	856,158	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322628	2,420,171	780,815	73.00
76.97	07697	CARDIAC REHABILITATION	1.075919	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.178316	1,727,028	307,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914408	149,072	136,313	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.507449	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		15,730,315	4,426,870	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		15,730,315		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.320903	10,288	3,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.403749	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066082	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194669	8,521	1,659	54.00
57.00	05700	CT SCAN	0.053532	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084041	0	0	58.00
60.00	06000	LABORATORY	0.223620	27,017	6,042	60.00
65.00	06500	RESPIRATORY THERAPY	0.141621	251,046	35,553	65.00
66.00	06600	PHYSICAL THERAPY	0.458662	735,920	337,539	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.236572	642,169	151,919	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.696176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322628	416,224	134,286	73.00
76.97	07697	CARDIAC REHABILITATION	1.075919	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.176754	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914408	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.507449	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		2,091,185	670,299	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,091,185		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E Part A Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	5,686,698		1.00
2.00	Outlier payments for discharges. (see instructions)	24,391		2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.	0		2.01
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)	46.75		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)	2.61		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	21.48		31.00
32.00	Sum of lines 30 and 31	24.09		32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.36		33.00
34.00	Disproportionate share adjustment (see instructions)	418,541		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	6,129,630		47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E Part A Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,884,391		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	6,884,391		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	458,162		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	488,168		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	50,390		58.00
59.00	Total (sum of amounts on lines 49 through 58)	7,881,111		59.00
60.00	Primary payer payments	3,130		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	7,877,981		61.00
62.00	Deductibles billed to program beneficiaries	818,864		62.00
63.00	Coinsurance billed to program beneficiaries	578		63.00
64.00	Allowable bad debts (see instructions)	180,732		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	126,512		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	156,231		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,185,051		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.	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	572,713		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	7,757,764		71.00
72.00	Interim payments	8,096,504		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)	-338,740		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	300,817		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,412	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,738,600	2.00
3.00	PPS payments	3,400,732	3.00
4.00	Outlier payment (see instructions)	895	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	5.00
6.00	Line 2 times line 5	3,222,673	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	75,393	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,412	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	10,577	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)	10,577	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)	10,577	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,165	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)	3,412	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,477,020	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)	841,735	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,638,697	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,638,697	30.00
31.00	Primary payer payments	282	31.00
32.00	Subtotal (line 30 minus line 31)	2,638,415	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)	199,333	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	139,533	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	159,193	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,777,948	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-37	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,777,985	40.00
41.00	Interim payments	3,034,115	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)	-256,130	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	1,271	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	316	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	316	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	985	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)	985	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)	985	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	669	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)	316	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	30	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	286	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)	286	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	286	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	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)	286	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	286	40.00
41.00	Interim payments	276	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)	10	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,474,638		2,562,829	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		467,480	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/25/2012	676,778	05/04/2012	3,806	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/04/2012	54,912		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)		621,866		3,806	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)		8,096,504		3,034,115	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		338,740		256,130	6.02
7.00	Total Medicare program liability (see instructions)		7,757,764		2,777,985	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001	Period:	Worksheet E-1
Component CCN: 145572	From 07/01/2011 To 06/30/2012	Part I Date/Time Prepared: 11/26/2012 3:01 pm
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,097,273		276	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,097,273		276	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		209,482		10	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,306,755		286	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,286,331	1.00
2.00	Routine service other pass through costs	206,234	2.00
3.00	Ancillary service other pass through costs	3,248	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,495,813	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	189,058	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,306,755	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,306,755	15.00
16.00	Interim payments	1,097,273	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	209,482	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	3,362	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 11/26/2012 3:01 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,211,770	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,289,158	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,424,957	0	0	0	7.00
8.00	Prepaid expenses	1,289,361	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,215,246	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,032,683	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	59,635,987	0	0	0	15.00
16.00	Accumulated depreciation	-53,127,115	0	0	0	16.00
17.00	Leasehold improvements	1,459,809	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	27,701,789	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	14,652,436	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)	54,355,589	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	46,410,421	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	10,093,151	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	56,503,572	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	130,074,407	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,999,911	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,140,544	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	740,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,491,219	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,371,674	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,345,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,304,492	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	38,649,492	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	47,021,166	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	83,053,241				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)	83,053,241	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	130,074,407	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/26/2012 3:01 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		85,848,337		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,795,093				2.00
3.00	Total (sum of line 1 and line 2)		83,053,244		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)		83,053,244		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		83,053,241		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/26/2012 3:01 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2012 3:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,044,795		9,044,795	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,295,520		2,295,520	7.00
8.00	NURSING FACILITY	1,062,323		1,062,323	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,402,638		12,402,638	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,325,043		1,325,043	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)	1,325,043		1,325,043	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,727,681		13,727,681	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	1	1	2	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	19,376,100	19,376,100	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		845,884	845,884	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,119,280	1,119,280	26.00
27.00	DME	0	2,958,580	2,958,580	27.00
27.01	OPERATING ROOM	9,351,986	12,249,191	21,601,177	27.01
27.02	DELIVERY ROOM & LABOR ROOM	451,640	128,905	580,545	27.02
27.03	ANESTHESIOLOGY	2,738,535	2,676,405	5,414,940	27.03
27.04	RADIOLOGY-DIAGNOSTIC	1,831,383	16,360,330	18,191,713	27.04
27.05	CT SCAN	1,263,065	7,836,623	9,099,688	27.05
27.06	MRI	347,586	5,833,897	6,181,483	27.06
27.07	LABORATORY	4,819,555	18,224,928	23,044,483	27.07
27.08	RESPIRATORY THERAPY	3,752,534	405,704	4,158,238	27.08
27.09	PHYSICAL THERAPY	1,520,279	1,966,932	3,487,211	27.09
27.10	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,243,672	1,683,383	2,927,055	27.10
27.11	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27.11
27.12	DRUGS CHARGED TO PATIENTS	5,734,876	2,930,518	8,665,394	27.12
27.13	CARDIAC REHAB	0	514,519	514,519	27.13
27.14	NURSING ADMIN	105	8,245	8,350	27.14
27.15	DIETARY	0	54,367	54,367	27.15
27.16	PHYSICIAN	0	587,180	587,180	27.16
27.17	NURSERY	332,172	0	332,172	27.17
27.18	EMERGENCY	5,630,192	17,655,130	23,285,322	27.18
27.19		0	0	0	27.19
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	52,745,263	113,416,103	166,161,366	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		69,744,965		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	4,989,146			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)		4,989,146		36.00
37.00	EXPENSES IN OTHER OPERATION REV	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)		74,734,111		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-3 | Date/Time Prepared: 11/26/2012 3:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	166,161,366	1.00
2.00	Less contractual allowances and discounts on patients' accounts	94,846,806	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,314,560	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,734,111	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,419,551	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	117,301	6.00
7.00	Income from investments	4,007,458	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01		0	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	313,705	24.02
24.03	INCREASE IN TEMP. RESTRICTED ASSETS	38,426	24.03
24.04		0	24.04
24.05	GHA ACCRUED NET PATIENT REVENUE AT Y	0	24.05
24.06	OTHER OPERATING REVENUE	2,477,513	24.06
24.07	GHA ACCRUED NET PATIENT REVENUE AT Y	72,070	24.07
24.08		0	24.08
24.09		0	24.09
24.10		0	24.10
25.00	Total other income (sum of lines 6-24)	7,026,473	25.00
26.00	Total (line 5 plus line 25)	3,606,922	26.00
27.00	ROUNDING	0	27.00
27.01	CY CHANGE IN UNREALIZED GAINS	2,241,241	27.01
27.02	CHANGE IN FV OF INT. RATE SWAP AGREE	3,457,404	27.02
27.03	CHANGE IN BENE. INT. PERPETUAL TRUST	703,370	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	6,402,015	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,795,093	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H | Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	163,278	0	0	0	35,787	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	237,644	0	13,078	0	0	6.00
7.00	Physical Therapy	68,730	0	0	0	0	7.00
8.00	Occupational Therapy	11,411	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	290	9.00
10.00	Medical Social Services	19,532	0	0	0	0	10.00
11.00	Home Health Aide	38,673	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	16,117	12.00
13.00	Drugs	0	0	0	0	489	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	1,697	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)	540,965	0	13,078	0	52,683	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H | Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I | PPS

		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	199,065	4,771	203,836	-1,573	202,263	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	250,722	0	250,722	0	250,722	6.00
7.00	Physical Therapy	68,730	0	68,730	0	68,730	7.00
8.00	Occupational Therapy	11,411	0	11,411	0	11,411	8.00
9.00	Speech Pathology	290	0	290	0	290	9.00
10.00	Medical Social Services	19,532	0	19,532	0	19,532	10.00
11.00	Home Health Aide	38,673	0	38,673	0	38,673	11.00
12.00	Supplies (see instructions)	16,117	0	16,117	0	16,117	12.00
13.00	Drugs	489	0	489	0	489	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	1,697	0	1,697	0	1,697	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	606,726	4,771	611,497	-1,573	609,924	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-1 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	202,263	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	250,722	0	0	0	0	6.00
7.00	Physical Therapy	68,730	0	0	0	0	7.00
8.00	Occupational Therapy	11,411	0	0	0	0	8.00
9.00	Speech Pathology	290	0	0	0	0	9.00
10.00	Medical Social Services	19,532	0	0	0	0	10.00
11.00	Home Health Aide	38,673	0	0	0	0	11.00
12.00	Supplies (see instructions)	16,117	0	0	0	0	12.00
13.00	Drugs	489	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	1,697	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)	609,924	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-1 Part I Date/Time Prepared: 11/26/2012 3:01 pm

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	202,263	202,263			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	250,722	124,395	375,117		6.00
7.00	Physical Therapy	68,730	34,101	102,831		7.00
8.00	Occupational Therapy	11,411	5,662	17,073		8.00
9.00	Speech Pathology	290	144	434		9.00
10.00	Medical Social Services	19,532	9,691	29,223		10.00
11.00	Home Health Aide	38,673	19,188	57,861		11.00
12.00	Supplies (see instructions)	16,117	7,997	24,114		12.00
13.00	Drugs	489	243	732		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	1,697	842	2,539		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	407,661		609,924		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-1 Part II Date/Time Prepared: 11/26/2012 3:01 pm

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-202,263	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-202,263	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-1 Part II Date/Time Prepared: 11/26/2012 3:01 pm

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	407,661		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	250,722		6.00
7.00	Physical Therapy	68,730		7.00
8.00	Occupational Therapy	11,411		8.00
9.00	Speech Pathology	290		9.00
10.00	Medical Social Services	19,532		10.00
11.00	Home Health Aide	38,673		11.00
12.00	Supplies (see instructions)	16,117		12.00
13.00	Drugs	489		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	1,697		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	407,661		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	202,263		25.00
26.00	Unit Cost Multiplier	0.496155		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part I Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	0	0	0	28,974	115,168	1.00
2.00	Skilled Nursing Care	375,117	0	0	0	0	2.00
3.00	Physical Therapy	102,831	0	0	0	0	3.00
4.00	Occupational Therapy	17,073	0	0	0	0	4.00
5.00	Speech Pathology	434	0	0	0	0	5.00
6.00	Medical Social Services	29,223	0	0	0	0	6.00
7.00	Home Health Aide	57,861	0	0	0	0	7.00
8.00	Supplies (see instructions)	24,114	0	0	0	0	8.00
9.00	Drugs	732	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	2,539	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)	609,924	0	0	28,974	115,168	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001
HHA CCN: 147142

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

Worksheet H-2
Part I
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	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	144,142	33,154	0	0	8,274	1.00
2.00	Skilled Nursing Care	375,117	86,280	0	0	0	2.00
3.00	Physical Therapy	102,831	23,652	0	0	0	3.00
4.00	Occupational Therapy	17,073	3,927	0	0	0	4.00
5.00	Speech Pathology	434	100	0	0	0	5.00
6.00	Medical Social Services	29,223	6,721	0	0	0	6.00
7.00	Home Health Aide	57,861	13,308	0	0	0	7.00
8.00	Supplies (see instructions)	24,114	5,546	0	0	0	8.00
9.00	Drugs	732	168	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	2,539	584	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)	754,066	173,440	0	0	8,274	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	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	573	168	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	573	168	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	51,599	237,169	0	237,169	1.00
2.00	Skilled Nursing Care	0	0	461,397	0	461,397	2.00
3.00	Physical Therapy	0	0	126,483	0	126,483	3.00
4.00	Occupational Therapy	0	0	21,000	0	21,000	4.00
5.00	Speech Pathology	0	0	534	0	534	5.00
6.00	Medical Social Services	0	0	35,944	0	35,944	6.00
7.00	Home Health Aide	0	0	71,169	0	71,169	7.00
8.00	Supplies (see instructions)	0	0	29,660	0	29,660	8.00
9.00	Drugs	0	0	1,641	0	1,641	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	3,123	0	3,123	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	51,599	988,120	0	988,120	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	145,722	607,119		2.00
3.00	Physical Therapy	39,946	166,429		3.00
4.00	Occupational Therapy	6,632	27,632		4.00
5.00	Speech Pathology	169	703		5.00
6.00	Medical Social Services	11,352	47,296		6.00
7.00	Home Health Aide	22,477	93,646		7.00
8.00	Supplies (see instructions)	9,367	39,027		8.00
9.00	Drugs	518	2,159		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	986	4,109		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	237,169	988,120		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.	0.315825			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	CAPITAL RELATED COSTS				Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)		
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	28,847	540,965	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	28,847	540,965		20.00
21.00	Total cost to be allocated	0	0	28,974	115,168		21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.004403	0.212894		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

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	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	144,142	0	0	208	0	1.00
2.00	Skilled Nursing Care	375,117	0	0	0	0	2.00
3.00	Physical Therapy	102,831	0	0	0	0	3.00
4.00	Occupational Therapy	17,073	0	0	0	0	4.00
5.00	Speech Pathology	434	0	0	0	0	5.00
6.00	Medical Social Services	29,223	0	0	0	0	6.00
7.00	Home Health Aide	57,861	0	0	0	0	7.00
8.00	Supplies (see instructions)	24,114	0	0	0	0	8.00
9.00	Drugs	732	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	2,539	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)	754,066	0	0	208	0	20.00
21.00	Total cost to be allocated	173,440	0	0	8,274	0	21.00
22.00	Unit cost multiplier	0.230006	0.000000	0.000000	39.778846	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 11/26/2012 3:01 pm

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	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	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	15,795	489	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	15,795	489	0	20.00
21.00	Total cost to be allocated	0	0	573	168	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.036277	0.343558	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I

PPS

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	27,530		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19)	27,530		20.00
21.00	Total cost to be allocated	51,599		21.00
22.00	Unit cost multiplier	1.874283		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	607,119		607,119	3,293	1.00
2.00	Physical Therapy	3.00	166,429	0	166,429	708	2.00
3.00	Occupational Therapy	4.00	27,632	0	27,632	175	3.00
4.00	Speech Pathology	5.00	703	0	703	6	4.00
5.00	Medical Social Services	6.00	47,296		47,296	44	5.00
6.00	Home Health Aide	7.00	93,646		93,646	581	6.00
7.00	Total (sum of lines 1-6)		942,825	0	942,825	4,807	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		99914	1,129	562		8.00
9.00	Physical Therapy		99914	227	71		9.00
10.00	Occupational Therapy		99914	49	22		10.00
11.00	Speech Pathology		99914	1	0		11.00
12.00	Medical Social Services		99914	10	21		12.00
13.00	Home Health Aide		99914	163	151		13.00
14.00	Total (sum of lines 8-13)			1,579	827		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	39,027	0	39,027	23,884	15.00
16.00	Cost of Drugs	9.00	2,159	0	2,159	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	0.458662	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.236572	0	0	4.00
5.00	Cost of Drugs	73.00	0.322628	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	184.37	1,129	562			1.00
2.00	Physical Therapy	235.07	227	71			2.00
3.00	Occupational Therapy	157.90	49	22			3.00
4.00	Speech Pathology	117.17	1	0			4.00
5.00	Medical Social Services	1,074.91	10	21			5.00
6.00	Home Health Aide	161.18	163	151			6.00
7.00	Total (sum of lines 1-6)		1,579	827			7.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	1.634023					15.00
16.00	Cost of Drugs	0.000000		0	0		16.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II Date/Time Prepared: 11/26/2012 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	208,154	103,616		311,770		1.00
2.00	Physical Therapy	53,361	16,690		70,051		2.00
3.00	Occupational Therapy	7,737	3,474		11,211		3.00
4.00	Speech Pathology	117	0		117		4.00
5.00	Medical Social Services	10,749	22,573		33,322		5.00
6.00	Home Health Aide	26,272	24,338		50,610		6.00
7.00	Total (sum of lines 1-6)	306,390	170,691		477,081		7.00

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

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

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/26/2012 3:01 pm

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

		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	272,150	145,406	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)	272,150	145,406	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	272,150	145,406	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	208,937	100,028	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	1,910	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	6,503	7,932	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,487	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	167	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)	219,004	107,960	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	219,004	107,960	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	219,004	107,960	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)	219,004	107,960	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	219,004	107,960	31.00
32.00	Interim payments (see instructions)	219,004	107,960	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-5 Date/Time Prepared: 11/26/2012 3:01 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		219,004		107,960	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)		219,004		107,960	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)		219,004		107,960	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet K | Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	236,467	0	0	16,783	82,374	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	236,467	0	0	16,783	82,374	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet K | Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	335,624	4,771	340,395	0	340,395	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	335,624	4,771	340,395	0	340,395	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-1

Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	57,389	0	0	0	127,498	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	57,389	0	0	0	127,498	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-1

Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		8,704	42,876	236,467		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	8,704	42,876	236,467		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet K-3 Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-3

Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	16,783	16,783		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	16,783	16,783		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-4 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	340,395	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	340,395	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-4 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0	0			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	340,395	0	340,395		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	340,395		340,395		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet K-4 Part II Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2011 To 06/30/2012 | Worksheet K-4 Part II Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	0	340,395		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	340,395		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0		39.00
40.00	Unit Cost Multiplier		0.000000		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		0	0	8,370	50,342	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	340,395	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	340,395	0	0	8,370	50,342	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part I
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	58,712	13,504	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	340,395	78,293	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	399,107	91,797	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part I
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	32,131	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	32,131	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	17,993	90,209			1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	418,688	0	418,688	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	32,131	0	32,131	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	17,993	541,028	0	541,028	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	83,780	502,468		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	6,429	38,560		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		541,028		34.00
35.00	Unit Cost Multiplier (see instructions)	0.200100			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	8,333	272,685	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	8,333	272,685		34.00
35.00	Total cost to be allocated	0	0	8,370	50,342		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	1.004440	0.184616		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	58,712	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	340,395	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	399,107	0	0	0	0	34.00
35.00	Total cost to be allocated	91,797	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.230006	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	285	99,995	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	285	99,995	0	34.00
35.00	Total cost to be allocated	0	0	0	32,131	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.321326	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/26/2012 3:01 pm

Hospice I

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	19,000		1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	19,000		34.00
35.00	Total cost to be allocated	17,993		35.00
36.00	Unit Cost Multiplier (see instructions)	0.947000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part III Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.458662	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.322628	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.507449	0	0	5.00
6.00	LABORATORY	60.00	0.223620	0	0	6.00
6.01	LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.236572	0	0	7.00
7.30	IMPL. DEV. CHARGED TO PATIENT	71.30				7.30
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
10.97	CARDIAC REHABILITATION	76.97	1.075919	0	0	10.97
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-6

Date/Time Prepared: 11/26/2012 3:01 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				541,028	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,436	2.00
3.00	Average cost per diem (line 1 divided by line 2)				121.96	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,649				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	445,032				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		429			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		52,321			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			358		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			43,662		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140001	Period: From 07/01/2011 To 06/30/2012	Worksheet L Parts I-III Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		455,379	1.00
2.00	Capital DRG outlier payments		2,783	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		22.44	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)		458,162	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 Date/Time Prepared: 11/26/2012 3:01 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	595,028	0	595,028	0	595,028	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,605,734	0	1,605,734	-63,036	1,542,698	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	500,338	0	500,338	-7,737	492,601	9.00
10.00	Subtotal (sum of lines 1-9)	2,701,100	0	2,701,100	-70,773	2,630,327	10.00
11.00	Physician Services Under Agreement	0	6,998,919	6,998,919	-108,230	6,890,689	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	6,998,919	6,998,919	-108,230	6,890,689	14.00
15.00	Medical Supplies	0	101,286	101,286	-1,566	99,720	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	29,339	29,339	-454	28,885	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	130,625	130,625	-2,020	128,605	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,701,100	7,129,544	9,830,644	-181,023	9,649,621	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	7,247	7,247	-112	7,135	29.00
30.00	Administrative Costs	27,485	97,902	125,387	-1,742	123,645	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,485	105,149	132,634	-1,854	130,780	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,728,585	7,234,693	9,963,278	-182,877	9,780,401	32.00

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

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 11/26/2012 3:01 pm

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	595,028		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,542,698		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	492,601		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,630,327		10.00
11.00	Physician Services Under Agreement	0	6,890,689		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	6,890,689		14.00
15.00	Medical Supplies	0	99,720		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	28,885		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	128,605		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	9,649,621		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-5,045	2,090		29.00
30.00	Administrative Costs	-114,451	9,194		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-119,496	11,284		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-119,496	9,660,905		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140001 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-2

Component CCN: 143493 | Date/Time Prepared: 11/26/2012 3:01 pm

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	16.50	76,459	4,200	69,300		1.00
2.00	Physician Assistant	3.00	9,806	2,100	6,300		2.00
3.00	Nurse Practitioner	2.50	8,958	2,100	5,250		3.00
4.00	Subtotal (sum of lines 1-3)	22.00	95,223		80,850	95,223	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)	22.00	95,223			95,223	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					9,649,621	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					9,649,621	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)					11,284	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,710,646	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,721,930	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					4,721,930	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					4,721,930	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					14,371,551	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3 Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		14,371,551	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		82,066	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		14,289,485	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		95,223	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)		95,223	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		150.06	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	150.06	150.06	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	18,089	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,714,435	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,714,435	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,516,539	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		729	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		787	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.)		1,989,543	16.04
16.05	Total program cost (see instructions)		1,990,330	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		226,719	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,990,330	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,125	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,007,455	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)		2,007,455	26.00
27.00	Interim payments		1,985,327	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)		22,128	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		35,302	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-4 | Date/Time Prepared: 11/26/2012 3:01 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,630,327	2,630,327	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005977	0.008927	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	15,721	23,481	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	10,073	5,828	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	25,794	29,309	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	9,649,621	9,649,621	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	4,721,930	4,721,930	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002673	0.003037	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,622	14,341	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	38,416	43,650	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,481	2,212	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	25.94	19.73	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	181	630	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,695	12,430	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)		82,066	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)		17,125	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/26/2012 3:01 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,919,981	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		05/04/2012	65,346	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)		65,346	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,985,327	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		22,128	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,007,455	7.00

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