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: 140019	Period: From 09/01/2011 To 08/31/2012	Worksheet S Parts I-III Date/Time Prepared: 1/28/2013 5:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/28/2013 Time: 5:53 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 SHELBY MEMORIAL HOSPITAL for the cost reporting period beginning 09/01/2011 and ending 08/31/2012 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	-11,895	-103,823	1,048,787	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	10,828	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-40,632		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	-1,067	-144,455	1,048,787	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 1/28/2013 5:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 SOUTH CEDAR	PO Box:			1.00
2.00	City: SHELBYVILLE	State: IL	Zip Code: 62565-1899	County: SHELBY	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	SHELBY MEMORIAL HOSPITAL	140019	99914	1	07/01/1966	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	SHELBY MEMORIAL HOSPITAL S/B	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SHELBY MEMORIAL HOSPITAL HHA	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHELBY MEMORIAL HOSPITAL RHC	143446	99914		06/05/1998	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)	09/01/2011	08/31/2012	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.	3	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.	340	0	0	0	0	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 1/28/2013 5:25 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.	09/01/2011	08/31/2012	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no 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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 1/28/2013 5:25 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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 1/28/2013 5:25 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.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	2.00	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

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		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.	1			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.	87,270	0	0	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.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 1/28/2013 5:25 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.						Y	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)						0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 1/28/2013 5:25 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.	N			5.00

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/18/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 1/28/2013 5:25 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.		KEVIN	WELLEN, CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.		BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		314-231-5544	KWELLEN@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 1/28/2013 5:25 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)	Y	01/18/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			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.		SENIOR MANAGING CONSULTANT	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2013 5:25 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	30	10,980	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)		30	10,980	0.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		30	10,980	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		30				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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2013 5:25 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	1,469	340	2,179		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	833	0	833		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	44		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,302	340	3,056		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	2,302	340	3,056		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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	3,808	515	4,323		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	2,685	0	6,800		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		53	361		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2013 5:25 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	468	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	136.20	0.00	0	468	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	0.00	6.83	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00	10.19	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	153.22	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2013 5:25 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)	114	685		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)	114	685		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part II Date/Time Prepared: 1/28/2013 5:25 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	6,770,240	0	6,770,240	318,705.33	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	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	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,376,388	22,509	1,398,897	42,240.74	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		283,738	0	283,738	6,166.50	11.00
12.00	Contract management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		226,678	0	226,678	3,266.00	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		1,243,908	0	1,243,908		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		225,974	0	225,974		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		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	55,746	0	55,746	2,131.50	26.00
27.00	Administrative & General	5.00	916,447	0	916,447	42,447.94	27.00
28.00	Administrative & General under contract (see inst.)		75,335	0	75,335	476.00	28.00
29.00	Maintenance & Repairs	6.00	277,267	0	277,267	13,318.55	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	30.00
31.00	Laundry & Linen Service	8.00	38,820	0	38,820	3,907.40	31.00
32.00	Housekeeping	9.00	196,131	-22,509	173,622	16,369.55	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	199,086	-131,079	68,007	6,263.60	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	131,079	131,079	12,072.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	432,639	0	432,639	14,557.20	38.00
39.00	Central Services and Supply	14.00	113,695	0	113,695	7,373.28	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	216,071	0	216,071	17,153.51	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part II | Date/Time Prepared: 1/28/2013 5:25 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	21.24		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A - Administrative	0.00		4.00
4.01	Physicians - Part A - Teaching	0.00		4.01
5.00	Physician-Part B	0.00		5.00
6.00	Non-physician-Part B	0.00		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	0.00		9.00
10.00	Excluded area salaries (see instructions)	33.12		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	46.01		11.00
12.00	Contract management and administrative services	0.00		12.00
13.00	Contract labor: Physician-Part A - Administrative	69.41		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	26.15		26.00
27.00	Administrative & General	21.59		27.00
28.00	Administrative & General under contract (see inst.)	158.27		28.00
29.00	Maintenance & Repairs	20.82		29.00
30.00	Operation of Plant	0.00		30.00
31.00	Laundry & Linen Service	9.93		31.00
32.00	Housekeeping	10.61		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	10.86		34.00
35.00	Dietary under contract (see instructions)	0.00		35.00
36.00	Cafeteria	10.86		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	29.72		38.00
39.00	Central Services and Supply	15.42		39.00
40.00	Pharmacy	0.00		40.00
41.00	Medical Records & Medical Records Library	12.60		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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part III Date/Time Prepared: 1/28/2013 5:25 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)		6,845,575	0	6,845,575	319,181.33	1.00
2.00	Excluded area salaries (see instructions)		1,376,388	22,509	1,398,897	42,240.74	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,469,187	-22,509	5,446,678	276,940.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		510,416	0	510,416	9,432.50	4.00
5.00	Subtotal wage-related costs (see inst.)		1,243,908	0	1,243,908	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		7,223,511	-22,509	7,201,002	286,373.09	6.00
7.00	Total overhead cost (see instructions)		2,521,237	-22,509	2,498,728	136,071.24	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part III Date/Time Prepared: 1/28/2013 5:25 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	21.45		1.00
2.00	Excluded area salaries (see instructions)	33.12		2.00
3.00	Subtotal salaries (line 1 minus line 2)	19.67		3.00
4.00	Subtotal other wages & related costs (see inst.)	54.11		4.00
5.00	Subtotal wage-related costs (see inst.)	22.84		5.00
6.00	Total (sum of lines 3 thru 5)	25.15		6.00
7.00	Total overhead cost (see instructions)	18.36		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part IV Date/Time Prepared: 1/28/2013 5:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	230,344	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	21,885	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	629,853	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)	8,283	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)	19,243	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	118,085	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	441,868	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	321	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	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,469,882	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part V Date/Time Prepared: 1/28/2013 5:25 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	379,630	0	1.00
2.00	Hospital	359,073	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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	20,557	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
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: 140019 | Component CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-4 | Date/Time Prepared: 1/28/2013 5:25 pm

Home Health Agency I | PPS

		1.00	
0.00	County	SHELBY	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,064	43	213	1,320	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	150.00	6.00	30.00	186.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.23	0.00	1.23	3.00
4.00	Director(s) and Assistant Director(s)		0.56	0.00	0.56	4.00
5.00	Other Administrative Personnel		0.88	0.00	0.88	5.00
6.00	Direct Nursing Service		2.61	0.00	2.61	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.88	0.00	0.88	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.03	0.00	0.03	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.63	0.00	0.63	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	982	114	38	12	1,146	21.00
22.00	Skilled Nursing Visit Charges	153,796	17,466	5,966	1,884	179,112	22.00
23.00	Physical Therapy Visits	717	9	5	5	736	23.00
24.00	Physical Therapy Visit Charges	121,909	1,539	855	855	125,158	24.00
25.00	Occupational Therapy Visits	297	6	1	0	304	25.00
26.00	Occupational Therapy Visit Charges	59,253	1,212	202	0	60,667	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	482	24	1	1	508	31.00
32.00	Home Health Aide Visit Charges	39,324	1,968	82	82	41,456	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,478	153	45	18	2,694	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)	374,282	22,185	7,105	2,821	406,393	35.00
36.00	Total Number of Episodes (standard/non outlier)	115		16	2	133	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	3,098	426	5,095	0	8,619	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-7 | Date/Time Prepared: 1/28/2013 5:25 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.	Y		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.	Y	04/13/1993	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	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	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	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	7	7	20.00
21.00		RMC	0	35	35	21.00
22.00		RMB	0	16	16	22.00
23.00		RMA	0	35	35	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	0	63	63	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	7	7	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	28	28	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	117	117	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	185	185	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	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	6	6	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	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	22	22	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	57	57	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	250	250	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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-7 | Date/Time Prepared: 1/28/2013 5:25 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	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	3	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	2	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	833	833	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).	99914	99914	201.00

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

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-8 | Date/Time Prepared: 1/28/2013 5:25 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	200 SOUTH CEDAR	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	SHELBYVILLE IL	62565 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes 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			08:00	17:00	11.00

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

		Provider name	CCN number
		1.00	2.00
14.00	Provider name, CCN number		14.00

		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)	N	0	0	0	0	15.00

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

Provider CCN: 140019
Component CCN: 143446

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-8

Date/Time Prepared:
1/28/2013 5:25 pm

Rural Health Clinic (RHC) I

Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/28/2013 5:25 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	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/28/2013 5:25 pm

		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-10 | Date/Time Prepared: 1/28/2013 5:25 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)	0.450215	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	38,209	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	540,183	6.00
7.00	Medicaid cost (line 1 times line 6)	243,198	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)	204,989	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)	204,989	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	948,195	132,941	1,081,136	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	426,892	59,852	486,744	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)	426,892	59,852	486,744	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,310,302	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	132,425	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,177,877	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	530,298	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,017,042	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,222,031	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A | Date/Time Prepared: 1/28/2013 5:25 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	CAP REL COSTS-BLDG & FIXT		948,780	948,780	-143,395	805,385	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	521,559	521,559	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	55,746	1,341,295	1,397,041	138,534	1,535,575	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	916,447	1,654,179	2,570,626	-282,936	2,287,690	5.00
6.00	00600	MAINTENANCE & REPAIRS	277,267	132,614	409,881	-2,815	407,066	6.00
7.00	00700	OPERATION OF PLANT	0	288,776	288,776	-24,242	264,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,820	25,442	64,262	0	64,262	8.00
9.00	00900	HOUSEKEEPING	196,131	8,960	205,091	-22,509	182,582	9.00
10.00	01000	DIETARY	199,086	226,627	425,713	-280,291	145,422	10.00
11.00	01100	CAFETERIA	0	0	0	280,291	280,291	11.00
13.00	01300	NURSING ADMINISTRATION	432,639	12,767	445,406	0	445,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,695	24,650	138,345	-4,574	133,771	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216,071	32,151	248,222	0	248,222	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	84,230	84,230	0	84,230	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	759,862	312,196	1,072,058	-422	1,071,636	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,834	119,111	241,945	-42,190	199,755	50.00
53.00	05300	ANESTHESIOLOGY	0	753	753	0	753	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449,727	291,177	740,904	0	740,904	54.00
60.00	06000	LABORATORY	460,191	660,543	1,120,734	0	1,120,734	60.00
65.00	06500	RESPIRATORY THERAPY	182,379	56,683	239,062	-33,351	205,711	65.00
66.00	06600	PHYSICAL THERAPY	304,914	15,636	320,550	0	320,550	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,721	76,721	32,824	109,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,055,994	1,055,994	7,192	1,063,186	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,896	1,875	35,771	0	35,771	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	741,213	29,300	770,513	35,099	805,612	88.00
90.00	09000	CLINIC	128,842	24,329	153,171	-7,923	145,248	90.00
91.00	09100	EMERGENCY	424,567	654,280	1,078,847	-277	1,078,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	80,738	108,779	189,517	-5,022	184,495	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	343,754	66,196	409,950	-2,711	407,239	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		243,155	243,155	-243,155	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,478,819	8,497,199	14,976,018	-80,314	14,895,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66	66	0	66	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	291,421	16,412	307,833	65,408	373,241	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	266	266	14,906	15,172	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,770,240	8,513,943	15,284,183	0	15,284,183	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-243,155	562,230		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	521,559		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-244,976	1,290,599		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-465,770	1,821,920		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	407,066		6.00
7.00	00700	OPERATION OF PLANT	0	264,534		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,262		8.00
9.00	00900	HOUSEKEEPING	0	182,582		9.00
10.00	01000	DIETARY	0	145,422		10.00
11.00	01100	CAFETERIA	-43,070	237,221		11.00
13.00	01300	NURSING ADMINISTRATION	0	445,406		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-16	133,755		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,872	239,350		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-84,230	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-49,094	1,022,542		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	199,755		50.00
53.00	05300	ANESTHESIOLOGY	0	753		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	740,904		54.00
60.00	06000	LABORATORY	0	1,120,734		60.00
65.00	06500	RESPIRATORY THERAPY	-18,822	186,889		65.00
66.00	06600	PHYSICAL THERAPY	0	320,550		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,749	107,796		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,063,186		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	35,771		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-794	804,818		88.00
90.00	09000	CLINIC	-3,174	142,074		90.00
91.00	09100	EMERGENCY	-383,042	695,528		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	184,495		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	-35,517	371,722		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,582,281	13,313,423		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	373,241		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	FARM EXPENSES	0	15,172		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,582,281	13,701,902		200.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-6 | Date/Time Prepared: 1/28/2013 5:25 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS MEDICAL CENTER SALARIES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	22,509	0	1.00
	TOTALS		22,509	0	
	B - TO RECLASS FIRE INSURANCE EXPENSE				
1.00	OTHER CAP REL COSTS	3.00	0	21,113	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,398	2.00
	TOTALS		0	22,511	
	C - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,970	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	11,970	
	D - TO RECLASS WORKERS COMPENSATION INS				
1.00	EMPLOYEE BENEFITS	4.00	0	116,649	1.00
	TOTALS		0	116,649	
	E - TO RECLASS RENTAL EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	84,109	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	84,109	
	F - TO RECLASS MEDICAL CENTER UTILITIES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24,242	1.00
	TOTALS		0	24,242	
	G - TO RECLASS PHYSICIAN BLDG DEPR				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17,259	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	17,259	
	H - TO RECLASS DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	413,220	1.00
	TOTALS		0	413,220	
	I - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	32,224	1.00
	TOTALS		0	32,224	
	J - TO RECLASS CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	131,079	149,212	1.00
	TOTALS		131,079	149,212	
	K - TO RECLASS REAL ESTATE TAXES				
1.00	OTHER CAP REL COSTS	3.00	0	14,822	1.00
2.00	FARM EXPENSES	194.00	0	14,906	2.00
	TOTALS		0	29,728	
	L - TO RECLASS ONCOLOGY PHARM COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,906	1.00
	TOTALS		0	7,906	
	M - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	243,155	1.00
	TOTALS		0	243,155	
	N - TO RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,824	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	32,824	
	O - TO RECLASS PENSION AUDIT COSTS				
1.00	EMPLOYEE BENEFITS	4.00	0	21,885	1.00
	TOTALS		0	21,885	
	P - TO RECLASS RHC PHYSICIAN RECRUITMENT				
1.00	RURAL HEALTH CLINIC	88.00	0	38,783	1.00
	TOTALS		0	38,783	
500.00	Grand Total: Increases		153,588	1,245,677	500.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-6 | Date/Time Prepared: 1/28/2013 5:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS MEDICAL CENTER SALARIES						
1.00	HOUSEKEEPING	9.00	22,509	0	0		1.00
	TOTALS		22,509	0			
	B - TO RECLASS FIRE INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,511	5		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	22,511			
	C - TO RECLASS TELEPHONE EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,574	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	714	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,684	0		3.00
4.00	EMERGENCY	91.00	0	277	0		4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	10	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	2,711	0		6.00
	TOTALS		0	11,970			
	D - TO RECLASS WORKERS COMPENSATION INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	116,649	0		1.00
	TOTALS		0	116,649			
	E - TO RECLASS RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,126	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	2,815	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	422	0		3.00
4.00	OPERATING ROOM	50.00	0	42,190	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	544	0		5.00
6.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	5,012	0		6.00
	TOTALS		0	84,109			
	F - TO RECLASS MEDICAL CENTER UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	24,242	0		1.00
	TOTALS		0	24,242			
	G - TO RECLASS PHYSICIAN BLDG DEPR						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,824	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,435	9		2.00
	TOTALS		0	17,259			
	H - TO RECLASS DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	413,220	9		1.00
	TOTALS		0	413,220			
	I - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,224	5		1.00
	TOTALS		0	32,224			
	J - TO RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	131,079	149,212	0		1.00
	TOTALS		131,079	149,212			
	K - TO RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,728	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	29,728			
	L - TO RECLASS ONCOLOGY PHARM COSTS						
1.00	CLINIC	90.00	0	7,906	0		1.00
	TOTALS		0	7,906			
	M - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	243,155	11		1.00
	TOTALS		0	243,155			
	N - TO RECLASS MEDICAL SUPPLIES						
1.00	RESPIRATORY THERAPY	65.00	0	32,807	0		1.00
2.00	CLINIC	90.00	0	17	0		2.00
	TOTALS		0	32,824			
	O - TO RECLASS PENSION AUDIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,885	0		1.00
	TOTALS		0	21,885			
	P - TO RECLASS RHC PHYSICIAN RECRUITMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38,783	0		1.00
	TOTALS		0	38,783			
500.00	Grand Total: Decreases		153,588	1,245,677			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/28/2013 5:25 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	825,826	142,282	0	142,282	0	1.00
2.00	Land Improvements	245,904	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,859,529	4,321,551	0	4,321,551	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,795,566	690,991	0	690,991	0	5.00
6.00	Movable Equipment	8,700,314	871,726	0	871,726	14,717	6.00
7.00	HIT designated Assets	177,478	3,900	0	3,900	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,604,617	6,030,450	0	6,030,450	14,717	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,604,617	6,030,450	0	6,030,450	14,717	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	946,037	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	946,037	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,395,093	0	16,395,093	0.535431	28,558	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,225,257	0	14,225,257	0.464569	24,779	2.00
3.00	Total (sum of lines 1-2)	30,620,350	0	30,620,350	1.000000	53,337	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/28/2013 5:25 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	968,108	0				1.00
2.00	Land Improvements	245,904	0				2.00
3.00	Buildings and Fixtures	15,181,080	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,486,557	0				5.00
6.00	Movable Equipment	9,557,323	0				6.00
7.00	HIT designated Assets	181,378	0				7.00
8.00	Subtotal (sum of lines 1-7)	30,620,350	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	30,620,350	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,743	948,780				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	2,743	948,780				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,936	0	36,494	522,993	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,886	0	31,665	405,785	84,109	2.00
3.00	Total (sum of lines 1-2)	14,822	0	68,159	928,778	84,109	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/28/2013 5:25 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	CAP REL COSTS-BLDG & FIXT	0	28,558	7,936	2,743	562,230	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	24,779	6,886	0	521,559	2.00
3.00	Total (sum of lines 1-2)	0	53,337	14,822	2,743	1,083,789	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8 | Date/Time Prepared: 1/28/2013 5:25 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-243,155	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-16	CENTRAL SERVICES & SUPPLY	14.00	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	-454,132			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-43,070	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,749	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-8,872	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist	A	-84,230	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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	SELF INSURANCE EXPENSE	A	-244,826	EMPLOYEE BENEFITS	4.00	33.00
33.01	ADVERTISING	A	-190,899	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	FOUNDATION EXPENSE	A	-7,857	ADMINISTRATIVE & GENERAL	5.00	33.02
33.04	MISCELLANEOUS INCOME	B	-250	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	NURSING SERVICES SOLD - HOSPITAL	B	-22,334	HOME HEALTH AGENCY	101.00	33.05
33.06	RECLYCLING INCOME	B	-1,762	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	LIFELINE INCOME	B	-13,183	HOME HEALTH AGENCY	101.00	33.07
33.09	SWITCHBOARD SALARY EXPENSE	A	-690	ADMINISTRATIVE & GENERAL	5.00	33.09
33.10	SWITCHBOARD BENEFIT EXPENSE	A	-150	EMPLOYEE BENEFITS	4.00	33.10
33.11	PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	LOBBYING DUES	A	-7,885	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13	FRA TAX	A	-251,526	ADMINISTRATIVE & GENERAL	5.00	33.13
33.14	PROMOTIONAL ITEMS	A	-1,196	ADMINISTRATIVE & GENERAL	5.00	33.14
33.15	PROMOTIONAL ITEMS	A	-794	RURAL HEALTH CLINIC	88.00	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,582,281			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8 | Date/Time Prepared: 1/28/2013 5:25 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11		1.00
2.00	Investment income - 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 - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - 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	SELF INSURANCE EXPENSE	0		33.00
33.01	ADVERTISING	0		33.01
33.02	FOUNDATION EXPENSE	0		33.02
33.04	MISCELLANEOUS INCOME	0		33.04
33.05	NURSING SERVICES SOLD - HOSPITAL	0		33.05
33.06	RECLYCLING INCOME	0		33.06
33.07	LIFELINE INCOME	0		33.07
33.09	SWITCHBOARD SALARY EXPENSE	0		33.09
33.10	SWITCHBOARD BENEFIT EXPENSE	0		33.10
33.11	PATIENT TELEPHONES	0		33.11
33.12	LOBBYING DUES	0		33.12
33.13	FRA TAX	0		33.13
33.14	PROMOTIONAL ITEMS	0		33.14
33.15	PROMOTIONAL ITEMS	0		33.15
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: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/28/2013 5:25 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		65.00	RESPIRATORY THERAPY	18,822	18,822	1.00
2.00		90.00	CLINIC	3,174	3,174	2.00
3.00		91.00	EMERGENCY	609,720	383,042	3.00
4.00		30.00	ADULTS & PEDIATRICS	49,094	49,094	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				680,810	454,132	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/28/2013 5:25 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		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		226,678	159,800	3,266	250,917	12,546	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		226,678		3,266	250,917	12,546	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	250,917	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	250,917	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/28/2013 5:25 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	18,822		1.00
2.00		0	3,174		2.00
3.00		0	383,042		3.00
4.00		0	49,094		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	454,132		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	562,230	562,230				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	521,559		521,559			2.00
4.00	00400	EMPLOYEE BENEFITS	1,290,599	6,366	5,905	1,302,870		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,821,920	67,348	62,476	177,713	2,129,457	5.00
6.00	00600	MAINTENANCE & REPAIRS	407,066	13,539	12,560	53,806	486,971	6.00
7.00	00700	OPERATION OF PLANT	264,534	13,026	12,083	0	289,643	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,262	11,379	10,556	7,533	93,730	8.00
9.00	00900	HOUSEKEEPING	182,582	5,407	5,015	33,693	226,697	9.00
10.00	01000	DIETARY	145,422	17,224	15,978	13,197	191,821	10.00
11.00	01100	CAFETERIA	237,221	6,041	5,604	25,437	274,303	11.00
13.00	01300	NURSING ADMINISTRATION	445,406	5,195	4,819	83,957	539,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,755	29,540	27,403	22,063	212,761	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	239,350	13,275	12,314	41,930	306,869	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,022,542	81,326	75,442	147,457	1,326,767	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	199,755	46,129	42,793	23,837	312,514	50.00
53.00	05300	ANESTHESIOLOGY	753	906	841	0	2,500	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,904	39,862	36,979	87,273	905,018	54.00
60.00	06000	LABORATORY	1,120,734	15,759	14,619	89,304	1,240,416	60.00
65.00	06500	RESPIRATORY THERAPY	186,889	11,115	10,311	35,392	243,707	65.00
66.00	06600	PHYSICAL THERAPY	320,550	29,109	27,004	59,171	435,834	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,796	0	0	0	107,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,063,186	5,965	5,534	0	1,074,685	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,771	10,783	10,003	6,578	63,135	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	804,818	36,366	33,735	143,838	1,018,757	88.00
90.00	09000	CLINIC	142,074	58,430	54,203	25,003	279,710	90.00
91.00	09100	EMERGENCY	695,528	15,132	14,038	82,391	807,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	184,495	13,471	12,497	15,668	226,131	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	371,722	9,537	8,847	66,708	456,814	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,313,423	562,230	521,559	1,241,949	13,252,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	66	0	0	0	66	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	373,241	0	0	60,921	434,162	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	15,172	0	0	0	15,172	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,701,902	562,230	521,559	1,302,870	13,701,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,129,457					5.00
6.00	00600	MAINTENANCE & REPAIRS	89,608	576,579				6.00
7.00	00700	OPERATION OF PLANT	53,297	15,812	358,752			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,247	13,814	8,837	133,628		8.00
9.00	00900	HOUSEKEEPING	41,715	6,563	4,199	0	279,174	9.00
10.00	01000	DIETARY	35,297	20,908	13,376	0	10,802	10.00
11.00	01100	CAFETERIA	50,475	7,333	4,691	0	3,788	11.00
13.00	01300	NURSING ADMINISTRATION	99,251	6,306	4,035	0	3,258	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,150	35,859	22,941	2,381	18,525	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,467	16,114	10,309	0	8,325	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	244,140	98,722	63,156	73,064	51,001	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,506	55,997	35,824	0	28,929	50.00
53.00	05300	ANESTHESIOLOGY	460	1,100	704	0	568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	166,533	48,389	30,957	17,080	24,998	54.00
60.00	06000	LABORATORY	228,250	19,130	12,239	4	9,883	60.00
65.00	06500	RESPIRATORY THERAPY	44,845	13,493	8,632	286	6,971	65.00
66.00	06600	PHYSICAL THERAPY	80,198	35,336	22,606	13,078	18,255	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,836	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,754	7,241	4,633	0	3,741	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	11,618	13,089	8,374	0	6,762	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	187,462	44,145	28,242	292	22,806	88.00
90.00	09000	CLINIC	51,470	70,929	45,377	21	36,643	90.00
91.00	09100	EMERGENCY	148,513	18,369	11,752	27,293	9,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	41,611	16,353	10,462	0	8,448	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	84,059	11,577	7,406	0	5,981	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,046,762	576,579	358,752	133,499	279,174	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,891	0	0	129	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	2,792	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,129,457	576,579	358,752	133,628	279,174	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	272,204					10.00
11.00	01100	CAFETERIA	0	340,590				11.00
13.00	01300	NURSING ADMINISTRATION	0	22,314	674,541			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,302	15,707	358,626		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,295	0	4,431	428,810	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	266,590	66,074	346,475	0	219,269	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,779	37,162	0	1,068	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,166	0	12,457	111,196	54.00
60.00	06000	LABORATORY	0	35,875	0	244,501	31,556	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,320	91,627	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,206	0	0	10,637	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	55,840	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,154	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,256	10,779	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	32,476	0	9,753	0	88.00
90.00	09000	CLINIC	0	11,148	53,257	9,330	55,084	90.00
91.00	09100	EMERGENCY	5,614	24,584	119,534	0	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	9,522	0	2,160	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	21,782	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	272,204	330,099	674,541	358,626	428,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,491	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	272,204	340,590	674,541	358,626	428,810	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,755,258	0	2,755,258		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	536,779	0	536,779		50.00
53.00	05300	ANESTHESIOLOGY	0	5,332	0	5,332		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,345,794	0	1,345,794		54.00
60.00	06000	LABORATORY	0	1,821,854	0	1,821,854		60.00
65.00	06500	RESPIRATORY THERAPY	0	421,881	0	421,881		65.00
66.00	06600	PHYSICAL THERAPY	0	633,150	0	633,150		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,472	0	183,472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,308,208	0	1,308,208		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	116,013	0	116,013		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,343,933	0	1,343,933		88.00
90.00	09000	CLINIC	0	612,969	0	612,969		90.00
91.00	09100	EMERGENCY	0	1,172,238	0	1,172,238		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	314,687	0	314,687		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	587,619	0	587,619		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	13,159,187	0	13,159,187		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	78	0	78		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	524,673	0	524,673		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FARM EXPENSES	0	17,964	0	17,964		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	13,701,902	0	13,701,902		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	6,366	5,905	12,271	12,271	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	67,348	62,476	129,824	1,672	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,539	12,560	26,099	507	6.00
7.00	00700	OPERATION OF PLANT	0	13,026	12,083	25,109	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,379	10,556	21,935	71	8.00
9.00	00900	HOUSEKEEPING	0	5,407	5,015	10,422	317	9.00
10.00	01000	DIETARY	0	17,224	15,978	33,202	124	10.00
11.00	01100	CAFETERIA	0	6,041	5,604	11,645	240	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,195	4,819	10,014	791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,540	27,403	56,943	208	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,275	12,314	25,589	395	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	81,326	75,442	156,768	1,389	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,129	42,793	88,922	225	50.00
53.00	05300	ANESTHESIOLOGY	0	906	841	1,747	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,862	36,979	76,841	822	54.00
60.00	06000	LABORATORY	0	15,759	14,619	30,378	841	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,115	10,311	21,426	333	65.00
66.00	06600	PHYSICAL THERAPY	0	29,109	27,004	56,113	557	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,965	5,534	11,499	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	10,783	10,003	20,786	62	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,366	33,735	70,101	1,355	88.00
90.00	09000	CLINIC	0	58,430	54,203	112,633	236	90.00
91.00	09100	EMERGENCY	0	15,132	14,038	29,170	776	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	13,471	12,497	25,968	148	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	9,537	8,847	18,384	628	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	562,230	521,559	1,083,789	11,697	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,657	0	0	18,657	574	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	14,906	0	0	14,906	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,563	562,230	521,559	1,117,352	12,271	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	131,496					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,533	32,139				6.00
7.00	00700	OPERATION OF PLANT	3,291	881	29,281			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,065	770	721	24,562		8.00
9.00	00900	HOUSEKEEPING	2,576	366	343	0	14,024	9.00
10.00	01000	DIETARY	2,180	1,165	1,092	0	543	10.00
11.00	01100	CAFETERIA	3,117	409	383	0	190	11.00
13.00	01300	NURSING ADMINISTRATION	6,129	352	329	0	164	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,418	1,999	1,872	438	931	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,487	898	841	0	418	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,075	5,502	5,155	13,427	2,561	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,551	3,121	2,924	0	1,453	50.00
53.00	05300	ANESTHESIOLOGY	28	61	57	0	29	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,284	2,697	2,527	3,140	1,256	54.00
60.00	06000	LABORATORY	14,095	1,066	999	1	496	60.00
65.00	06500	RESPIRATORY THERAPY	2,769	752	705	53	350	65.00
66.00	06600	PHYSICAL THERAPY	4,952	1,970	1,845	2,404	917	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,225	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,212	404	378	0	188	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	717	730	683	0	340	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,576	2,461	2,305	54	1,146	88.00
90.00	09000	CLINIC	3,178	3,954	3,704	4	1,841	90.00
91.00	09100	EMERGENCY	9,171	1,024	959	5,017	477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,570	912	854	0	424	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	5,191	645	605	0	300	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,390	32,139	29,281	24,538	14,024	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,933	0	0	24	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	172	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	131,496	32,139	29,281	24,562	14,024	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	38,306					10.00
11.00	01100	CAFETERIA	0	15,984				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,047	18,826			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	530	438	65,777		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,234	0	813	33,675	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,516	3,102	9,671	0	17,220	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	365	1,037	0	84	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,369	0	2,285	8,732	54.00
60.00	06000	LABORATORY	0	1,684	0	44,845	2,478	60.00
65.00	06500	RESPIRATORY THERAPY	0	578	2,557	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	807	0	0	835	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,242	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,696	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	106	301	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,524	0	1,789	0	88.00
90.00	09000	CLINIC	0	523	1,486	1,711	4,326	90.00
91.00	09100	EMERGENCY	790	1,154	3,336	0	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	447	0	396	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,022	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,306	15,492	18,826	65,777	33,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	492	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	38,306	15,984	18,826	65,777	33,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		267,386	0	267,386		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		101,682	0	101,682		50.00
53.00	05300	ANESTHESIOLOGY		1,922	0	1,922		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		109,953	0	109,953		54.00
60.00	06000	LABORATORY		96,883	0	96,883		60.00
65.00	06500	RESPIRATORY THERAPY		29,523	0	29,523		65.00
66.00	06600	PHYSICAL THERAPY		70,400	0	70,400		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,467	0	11,467		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		28,377	0	28,377		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		23,725	0	23,725		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		92,311	0	92,311		88.00
90.00	09000	CLINIC		133,596	0	133,596		90.00
91.00	09100	EMERGENCY		51,874	0	51,874		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		31,719	0	31,719		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY		26,775	0	26,775		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,077,593	0	1,077,593		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1	0	1		190.00
191.00	19100	RESEARCH		0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		24,680	0	24,680		192.00
193.00	19300	NONPAID WORKERS		0	0	0		193.00
194.00	07950	FARM EXPENSES		15,078	0	15,078		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,117,352	0	1,117,352		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS	843	843	6,713,804			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	915,757	-2,129,457	11,572,445	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	277,267	0	486,971	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	289,643	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	38,820	0	93,730	8.00
9.00	00900	HOUSEKEEPING	716	716	173,622	0	226,697	9.00
10.00	01000	DIETARY	2,281	2,281	68,007	0	191,821	10.00
11.00	01100	CAFETERIA	800	800	131,079	0	274,303	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	432,639	0	539,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	113,695	0	212,761	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	216,071	0	306,869	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	759,862	0	1,326,767	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	122,834	0	312,514	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	0	2,500	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	449,727	0	905,018	54.00
60.00	06000	LABORATORY	2,087	2,087	460,191	0	1,240,416	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	182,379	0	243,707	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	304,914	0	435,834	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	107,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	0	1,074,685	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	33,896	0	63,135	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	741,213	0	1,018,757	88.00
90.00	09000	CLINIC	7,738	7,738	128,842	0	279,710	90.00
91.00	09100	EMERGENCY	2,004	2,004	424,567	0	807,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	80,738	0	226,131	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	343,754	0	456,814	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,457	74,457	6,399,874	-2,129,457	11,123,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	66	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	313,930	0	434,162	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	0	0	0	15,172	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	562,230	521,559	1,302,870		2,129,457	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.551070	7.004835	0.194058		0.184011	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,271		131,496	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001828		0.011363	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	99,624			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	11,880	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	1,775	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	54,471	10,770	11,635	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	0	6,109	0	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	12,734	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	3	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	213	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	9,750	3,855	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	218	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	16	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	20,348	2,004	245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,902	61,177	99,528	58,954	11,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	96	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	576,579	358,752	133,628	279,174	272,204	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.166306	5.864165	1.341323	4.735455	22.912795	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,139	29,281	24,562	14,024	38,306	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.510938	0.478628	0.246547	0.237880	3.224411	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/28/2013 5:25 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	222,194					11.00
13.00	01300	NURSING ADMINISTRATION	14,557	92,118				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,373	2,145	703,542			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,154	0	8,692	10,844		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,106	47,316	0	5,545		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,075	5,075	0	27	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,027	0	24,437	2,812	0	54.00
60.00	06000	LABORATORY	23,404	0	479,655	798	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,037	12,513	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,225	0	0	269	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	109,545	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	39,537	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,472	1,472	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,187	0	19,134	0	0	88.00
90.00	09000	CLINIC	7,273	7,273	18,304	1,393	0	90.00
91.00	09100	EMERGENCY	16,038	16,324	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	6,212	0	4,238	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	14,210	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,350	92,118	703,542	10,844	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,844	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	340,590	674,541	358,626	428,810	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.532850	7.322575	0.509744	39.543526	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,984	18,826	65,777	33,675	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.071937	0.204368	0.093494	3.105404	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,755,258		2,755,258	0	2,755,258	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,779		536,779	0	536,779	50.00
53.00	05300	ANESTHESIOLOGY	5,332		5,332	0	5,332	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,345,794		1,345,794	0	1,345,794	54.00
60.00	06000	LABORATORY	1,821,854		1,821,854	0	1,821,854	60.00
65.00	06500	RESPIRATORY THERAPY	421,881	0	421,881	0	421,881	65.00
66.00	06600	PHYSICAL THERAPY	633,150	0	633,150	0	633,150	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,472		183,472	0	183,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,208		1,308,208	0	1,308,208	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	116,013		116,013	0	116,013	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,343,933		1,343,933	0	1,343,933	88.00
90.00	09000	CLINIC	612,969		612,969	0	612,969	90.00
91.00	09100	EMERGENCY	1,172,238		1,172,238	0	1,172,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,018		368,018		368,018	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	314,687		314,687	0	314,687	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	587,619		587,619		587,619	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,527,205	0	13,527,205	0	13,527,205	200.00
201.00		Less Observation Beds	368,018		368,018		368,018	201.00
202.00		Total (see instructions)	13,159,187	0	13,159,187	0	13,159,187	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,661,781		3,661,781			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,935	941,608	977,543	0.549110	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	6,519	328,636	335,155	0.015909	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,087,634	6,925,694	8,013,328	0.167944	0.000000	54.00
60.00	06000	LABORATORY	1,352,762	5,694,617	7,047,379	0.258515	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	333,123	924,809	1,257,932	0.335377	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	105,669	1,088,324	1,193,993	0.530279	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	488,779	221,498	710,277	0.258310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838,520	1,066,044	1,904,564	0.686881	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	96,276	96,276	1.205004	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	705,405	705,405			88.00
90.00	09000	CLINIC	11,036	573,745	584,781	1.048203	0.000000	90.00
91.00	09100	EMERGENCY	147,525	2,027,072	2,174,597	0.539060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	88,533	357,309	445,842	0.825445	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	261,296	261,296	1.204331	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	675,934	675,934			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,157,816	21,888,267	30,046,083			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,157,816	21,888,267	30,046,083			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.549110	50.00
53.00	05300	ANESTHESIOLOGY	0.015909	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167944	54.00
60.00	06000	LABORATORY	0.258515	60.00
65.00	06500	RESPIRATORY THERAPY	0.335377	65.00
66.00	06600	PHYSICAL THERAPY	0.530279	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258310	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686881	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	1.205004	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	1.048203	90.00
91.00	09100	EMERGENCY	0.539060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.825445	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.204331	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XIX | Hospital

		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	2,755,258		2,755,258	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,779		536,779	0	0	50.00
53.00	05300	ANESTHESIOLOGY	5,332		5,332	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,345,794		1,345,794	0	0	54.00
60.00	06000	LABORATORY	1,821,854		1,821,854	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	421,881	0	421,881	0	0	65.00
66.00	06600	PHYSICAL THERAPY	633,150	0	633,150	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,472		183,472	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,208		1,308,208	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	116,013		116,013	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,343,933		1,343,933	0	0	88.00
90.00	09000	CLINIC	612,969		612,969	0	0	90.00
91.00	09100	EMERGENCY	1,172,238		1,172,238	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,018		368,018		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	314,687		314,687	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	587,619		587,619		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,527,205	0	13,527,205	0	0	200.00
201.00		Less Observation Beds	368,018		368,018		0	201.00
202.00		Total (see instructions)	13,159,187	0	13,159,187	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XIX | Hospital

		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	3,661,781		3,661,781			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,935	941,608	977,543	0.549110	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	6,519	328,636	335,155	0.015909	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,087,634	6,925,694	8,013,328	0.167944	0.000000	54.00
60.00	06000	LABORATORY	1,352,762	5,694,617	7,047,379	0.258515	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	333,123	924,809	1,257,932	0.335377	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	105,669	1,088,324	1,193,993	0.530279	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	488,779	221,498	710,277	0.258310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	838,520	1,066,044	1,904,564	0.686881	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	96,276	96,276	1.205004	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	705,405	705,405	1.905193	0.000000	88.00
90.00	09000	CLINIC	11,036	573,745	584,781	1.048203	0.000000	90.00
91.00	09100	EMERGENCY	147,525	2,027,072	2,174,597	0.539060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	88,533	357,309	445,842	0.825445	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	261,296	261,296	1.204331	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	675,934	675,934			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,157,816	21,888,267	30,046,083			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,157,816	21,888,267	30,046,083			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part II Date/Time Prepared: 1/28/2013 5:25 pm

Title XIX | Hospital

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	536,779	101,682	435,097	0	0	50.00
53.00	05300	ANESTHESIOLOGY	5,332	1,922	3,410	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,345,794	109,953	1,235,841	0	0	54.00
60.00	06000	LABORATORY	1,821,854	96,883	1,724,971	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	421,881	29,523	392,358	0	0	65.00
66.00	06600	PHYSICAL THERAPY	633,150	70,400	562,750	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,472	11,467	172,005	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,208	28,377	1,279,831	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	116,013	23,725	92,288	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,343,933	92,311	1,251,622	0	0	88.00
90.00	09000	CLINIC	612,969	133,596	479,373	0	0	90.00
91.00	09100	EMERGENCY	1,172,238	51,874	1,120,364	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,018	38,002	330,016	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	314,687	31,719	282,968	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	587,619	26,775	560,844	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	10,771,947	848,209	9,923,738	0	0	200.00
201.00		Less Observation Beds	368,018	38,002	330,016	0	0	201.00
202.00		Total (line 200 minus line 201)	10,403,929	810,207	9,593,722	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part II Date/Time Prepared: 1/28/2013 5:25 pm

Title XIX | Hospital

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	536,779	977,543	0.549110		50.00
53.00	05300	ANESTHESIOLOGY	5,332	335,155	0.015909		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,345,794	8,013,328	0.167944		54.00
60.00	06000	LABORATORY	1,821,854	7,047,379	0.258515		60.00
65.00	06500	RESPIRATORY THERAPY	421,881	1,257,932	0.335377		65.00
66.00	06600	PHYSICAL THERAPY	633,150	1,193,993	0.530279		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,472	710,277	0.258310		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,308,208	1,904,564	0.686881		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	116,013	96,276	1.205004		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,343,933	705,405	1.905193		88.00
90.00	09000	CLINIC	612,969	584,781	1.048203		90.00
91.00	09100	EMERGENCY	1,172,238	2,174,597	0.539060		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,018	445,842	0.825445		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	314,687	261,296	1.204331		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	587,619	675,934	0.869344		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	10,771,947	26,384,302			200.00
201.00		Less Observation Beds	368,018	0			201.00
202.00		Total (line 200 minus line 201)	10,403,929	26,384,302			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part I Date/Time Prepared: 1/28/2013 5:25 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	267,386	16,097	251,289	2,540	98.93	30.00
200.00		Total (lines 30-199)	267,386		251,289	2,540		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part I Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,469	145,328		30.00
200.00		Total (lines 30-199)	1,469	145,328		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part II Date/Time Prepared: 1/28/2013 5:25 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	101,682	977,543	0.104018	1,894	197	50.00
53.00	05300	ANESTHESIOLOGY	1,922	335,155	0.005735	1,433	8	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,953	8,013,328	0.013721	981,457	13,467	54.00
60.00	06000	LABORATORY	96,883	7,047,379	0.013747	1,072,775	14,747	60.00
65.00	06500	RESPIRATORY THERAPY	29,523	1,257,932	0.023469	237,765	5,580	65.00
66.00	06600	PHYSICAL THERAPY	70,400	1,193,993	0.058962	23,477	1,384	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,467	710,277	0.016144	318,394	5,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,377	1,904,564	0.014899	528,427	7,873	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,725	96,276	0.246427	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	92,311	705,405	0.130862	0	0	88.00
90.00	09000	CLINIC	133,596	584,781	0.228455	320	73	90.00
91.00	09100	EMERGENCY	51,874	2,174,597	0.023855	112,709	2,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,002	445,842	0.085236	67,877	5,786	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	31,719	261,296	0.121391	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	821,434	25,708,368		3,346,528	56,944	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part III Date/Time Prepared: 1/28/2013 5:25 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	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part III Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,540	0.00	1,469	0		30.00
200.00		Total (lines 30-199)	2,540		1,469	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV | Date/Time Prepared: 1/28/2013 5:25 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	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	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
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	977,543	0.000000	0.000000	1,894	50.00
53.00	05300	ANESTHESIOLOGY	0	335,155	0.000000	0.000000	1,433	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,013,328	0.000000	0.000000	981,457	54.00
60.00	06000	LABORATORY	0	7,047,379	0.000000	0.000000	1,072,775	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,257,932	0.000000	0.000000	237,765	65.00
66.00	06600	PHYSICAL THERAPY	0	1,193,993	0.000000	0.000000	23,477	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	710,277	0.000000	0.000000	318,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,904,564	0.000000	0.000000	528,427	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	96,276	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	705,405	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	584,781	0.000000	0.000000	320	90.00
91.00	09100	EMERGENCY	0	2,174,597	0.000000	0.000000	112,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	445,842	0.000000	0.000000	67,877	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	261,296	0.000000	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	25,708,368			3,346,528	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	488,017	0		50.00
53.00	05300	ANESTHESIOLOGY	0	163,436	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,046,926	0		54.00
60.00	06000	LABORATORY	0	112,365	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	464,220	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	107,425	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	663,720	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	64,226	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	37,116	0		90.00
91.00	09100	EMERGENCY	0	603,955	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	166,635	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	5,918,041	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V Date/Time Prepared: 1/28/2013 5:25 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	0.549110	488,017	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.015909	163,436	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167944	3,046,926	0	0		54.00
60.00	06000	LABORATORY	0.258515	112,365	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.335377	464,220	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.530279	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258310	107,425	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686881	663,720	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1.205004	64,226	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
90.00	09000	CLINIC	1.048203	37,116	0	0		90.00
91.00	09100	EMERGENCY	0.539060	603,955	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.825445	166,635	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.204331	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0		97.00
200.00		Subtotal (see instructions)		5,918,041	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,918,041	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V Date/Time Prepared: 1/28/2013 5:25 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	267,975	0	0		50.00
53.00	05300	ANESTHESIOLOGY	2,600	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	511,713	0	0		54.00
60.00	06000	LABORATORY	29,048	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	155,689	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,749	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	455,897	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	77,393	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	38,905	0	0		90.00
91.00	09100	EMERGENCY	325,568	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	137,548	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Subtotal (see instructions)	2,030,085	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,030,085	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/28/2013 5:25 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)	3,417	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,540	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)	2,179	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)	833	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)	44	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,469	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)	833	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	188.27	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	192.90	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.79	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.79	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,755,258	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)	160,686	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)	5,183	25.00
26.00	Total swing-bed cost (see instructions)	165,869	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,589,389	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,197,417	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,197,417	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.809838	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)	1,467.38	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,589,389	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,019.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,497,557	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,497,557	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/28/2013 5:25 pm

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,097,742	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,595,299	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)	145,328	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	56,944	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	202,272	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,393,027	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)	160,686	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	160,686	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)	361	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,019.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	368,018	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/28/2013 5:25 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	267,386	2,589,389	0.103262	368,018	38,002	90.00
91.00	Nursing School cost	0	2,589,389	0.000000	368,018	0	91.00
92.00	Allied health cost	0	2,589,389	0.000000	368,018	0	92.00
93.00	All other Medical Education	0	2,589,389	0.000000	368,018	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-3 | Date/Time Prepared: 1/28/2013 5:25 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		2,104,840		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549110	1,894	1,040	50.00
53.00	05300	ANESTHESIOLOGY	0.015909	1,433	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167944	981,457	164,830	54.00
60.00	06000	LABORATORY	0.258515	1,072,775	277,328	60.00
65.00	06500	RESPIRATORY THERAPY	0.335377	237,765	79,741	65.00
66.00	06600	PHYSICAL THERAPY	0.530279	23,477	12,449	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258310	318,394	82,244	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686881	528,427	362,966	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.205004	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.048203	320	335	90.00
91.00	09100	EMERGENCY	0.539060	112,709	60,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.825445	67,877	56,029	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.204331	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		3,346,528	1,097,742	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)		3,346,528		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-3 | Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		849,480		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.549110	368	202	50.00
53.00	05300	ANESTHESIOLOGY	0.015909	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167944	99,371	16,689	54.00
60.00	06000	LABORATORY	0.258515	246,805	63,803	60.00
65.00	06500	RESPIRATORY THERAPY	0.335377	92,579	31,049	65.00
66.00	06600	PHYSICAL THERAPY	0.530279	72,152	38,261	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.258310	142,674	36,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.686881	263,015	180,660	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.205004	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.048203	0	0	90.00
91.00	09100	EMERGENCY	0.539060	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.825445	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.204331	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		916,964	367,518	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		916,964		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E Part A Date/Time Prepared: 1/28/2013 5:25 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	2,015,588		1.00
2.00	Outlier payments for discharges. (see instructions)	0		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)	26.62		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)	7.24		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	15.60		31.00
32.00	Sum of lines 30 and 31	22.84		32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.03		33.00
34.00	Disproportionate share adjustment (see instructions)	161,852		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)	2,177,440		47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part A Date/Time Prepared: 1/28/2013 5:25 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)	2,488,590		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	2,488,590		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	160,657		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	2,649,247		59.00
60.00	Primary payer payments	0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,649,247		61.00
62.00	Deductibles billed to program beneficiaries	338,692		62.00
63.00	Coinsurance billed to program beneficiaries	4,835		63.00
64.00	Allowable bad debts (see instructions)	104,588		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	73,212		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	104,588		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,378,932		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	41,538		70.96
70.97	Low Volume Payment-2	397,475		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)	2,817,945		71.00
72.00	Interim payments	2,829,840		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)	-11,895		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		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: 140019	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/28/2013 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,030,085	2.00
3.00	PPS payments	1,411,018	3.00
4.00	Outlier payment (see instructions)	748	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.849	5.00
6.00	Line 2 times line 5	1,723,542	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	81.91	7.00
8.00	Transitional corridor payment (see instructions)	265,010	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	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)	1,676,776	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)	362,160	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,314,616	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,314,616	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,314,616	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)	69,122	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	48,385	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,122	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,363,001	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,363,001	40.00
41.00	Interim payments	1,466,824	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)	-103,823	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 1/28/2013 5:25 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		3,274,092		1,462,298	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	05/11/2012	353,889	05/11/2012	4,526	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	08/28/2012	798,141		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)		-444,252		4,526	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,829,840		1,466,824	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		11,895		103,823	6.02
7.00	Total Medicare program liability (see instructions)		2,817,945		1,363,001	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: 140019 | Component CCN: 14U019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		186,206		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		186,206		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		10,828		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		197,034		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140019	Period: From 09/01/2011 To 08/31/2012	Worksheet E-1 Part II Date/Time Prepared: 1/28/2013 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	685	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,469	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,179	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	30,046,083	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,081,136	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,048,787	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	1,048,787	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-2 | Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	221,525	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	833	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	221,525	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	221,525	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	221,525	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	35,319	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	186,206	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	10,828	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	10,828	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	197,034	0	19.00
20.00	Interim payments	186,206	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	10,828	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G | Date/Time Prepared: 1/28/2013 5:25 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	271,751	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	6,827,496	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,007,076	0	0	0	6.00
7.00	Inventory	164,502	0	0	0	7.00
8.00	Prepaid expenses	255,282	0	0	0	8.00
9.00	Other current assets	1,494,187	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,006,142	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	968,109	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-332,969	0	0	0	14.00
15.00	Buildings	15,426,984	0	0	0	15.00
16.00	Accumulated depreciation	-7,458,658	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,554,944	0	0	0	19.00
20.00	Accumulated depreciation	-3,400,149	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	9,666,412	0	0	0	23.00
24.00	Accumulated depreciation	-7,682,457	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,742,216	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	22,282,787	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	709,772	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,992,559	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,740,917	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	661,845	0	0	0	37.00
38.00	Salaries, wages, and fees payable	315,366	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	300,000	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	910,223	0	0	0	43.00
44.00	Other current liabilities	387,504	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,574,938	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,400,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	432,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,832,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,406,938	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,333,979				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)	28,333,979	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,740,917	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-1 | Date/Time Prepared: 1/28/2013 5:25 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		26,875,807		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,458,172				2.00
3.00	Total (sum of line 1 and line 2)		28,333,979		0		3.00
4.00		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)		28,333,979		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,333,979		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-1 | Date/Time Prepared: 1/28/2013 5:25 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		0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/28/2013 5:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,751,575		2,751,575	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	899,430		899,430	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,651,005		3,651,005	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,651,005		3,651,005	17.00
18.00	Ancillary services	4,067,728	17,757,983	21,825,711	18.00
19.00	Outpatient services	247,094	3,234,513	3,481,607	19.00
20.00	RURAL HEALTH CLINIC	0	705,405	705,405	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		675,934	675,934	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	5,613	656,496	662,109	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,971,440	23,030,331	31,001,771	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,284,183		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	FARM EXPENSES	266			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)		266		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,283,917		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-3 | Date/Time Prepared: 1/28/2013 5:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,001,771	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,107,751	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,894,020	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,283,917	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,389,897	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	311,664	6.00
7.00	Income from investments	1,819,310	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	43,070	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	1,749	17.00
18.00	Revenue from sale of medical records and abstracts	8,872	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	68,071	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	212,397	24.00
24.01	FARM INCOME	106,998	24.01
24.02	GAIN ON SALE OF EQUIPMENT	5,925	24.02
24.03	LIFELINE INCOME	13,183	24.03
24.04	NURSING SERVICES	22,334	24.04
24.05	PROFESSIONAL FESS	3,000	24.05
24.06	MISCELLANEOUS INCOME	3,897	24.06
24.07	EHR INCENTIVE PAYMENT	1,495,187	24.07
25.00	Total other income (sum of lines 6-24)	4,115,657	25.00
26.00	Total (line 5 plus line 25)	1,725,760	26.00
27.00	FARM EXPENSE	266	27.00
27.01	FOUNDATION DISBURSEMENTS	267,322	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	267,588	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,458,172	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H Date/Time Prepared: 1/28/2013 5:25 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	63,544	0	0	0	19,929	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	157,295	0	11,758	0	0	6.00
7.00	Physical Therapy	57,603	0	7,464	0	0	7.00
8.00	Occupational Therapy	17,717	0	2,296	0	0	8.00
9.00	Speech Pathology	54	0	6	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	47,541	0	4,186	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	TELEMEDICINE	0	0	0	20,557	0	23.00
24.00	Total (sum of lines 1-23)	343,754	0	25,710	20,557	19,929	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: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H | Date/Time Prepared: 1/28/2013 5:25 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	83,473	-2,711	80,762	0	80,762	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	169,053	0	169,053	-22,334	146,719	6.00
7.00	Physical Therapy	65,067	0	65,067	0	65,067	7.00
8.00	Occupational Therapy	20,013	0	20,013	0	20,013	8.00
9.00	Speech Pathology	60	0	60	0	60	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,727	0	51,727	0	51,727	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	TELEMEDICINE	20,557	0	20,557	-13,183	7,374	23.00
24.00	Total (sum of lines 1-23)	409,950	-2,711	407,239	-35,517	371,722	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: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	80,762	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	146,719	0	0	0	0	6.00
7.00	Physical Therapy	65,067	0	0	0	0	7.00
8.00	Occupational Therapy	20,013	0	0	0	0	8.00
9.00	Speech Pathology	60	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,727	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	TELEMEDICINE	7,374	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	371,722	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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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	80,762	80,762			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	146,719	40,724	187,443		6.00
7.00	Physical Therapy	65,067	18,061	83,128		7.00
8.00	Occupational Therapy	20,013	5,555	25,568		8.00
9.00	Speech Pathology	60	17	77		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Home Health Aide	51,727	14,358	66,085		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	TELEMEDICINE	7,374	2,047	9,421		23.00
24.00	Total (sum of lines 1-23)	290,960		371,722		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-1 Part II Date/Time Prepared: 1/28/2013 5:25 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	-80,762	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	TELEMEDICINE	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-80,762	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: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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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	290,960		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	146,719		6.00
7.00	Physical Therapy	65,067		7.00
8.00	Occupational Therapy	20,013		8.00
9.00	Speech Pathology	60		9.00
10.00	Medical Social Services	0		10.00
11.00	Home Health Aide	51,727		11.00
12.00	Supplies (see instructions)	0		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	TELEMEDICINE	7,374		23.00
24.00	Total (sum of lines 1-23)	290,960		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	80,762		25.00
26.00	Unit Cost Multiplier	0.277571		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

Worksheet H-2 Part I Date/Time Prepared: 1/28/2013 5:25 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	9,537	8,847	12,331	30,715	1.00
2.00	Skilled Nursing Care	187,443	0	0	30,525	217,968	2.00
3.00	Physical Therapy	83,128	0	0	11,178	94,306	3.00
4.00	Occupational Therapy	25,568	0	0	3,438	29,006	4.00
5.00	Speech Pathology	77	0	0	10	87	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	66,085	0	0	9,226	75,311	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	TELEMEDICINE	9,421	0	0	0	9,421	19.00
20.00	Total (sum of lines 1-19) (2)	371,722	9,537	8,847	66,708	456,814	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: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	5,652	11,577	7,406	0	5,981	1.00
2.00	Skilled Nursing Care	40,109	0	0	0	0	2.00
3.00	Physical Therapy	17,353	0	0	0	0	3.00
4.00	Occupational Therapy	5,337	0	0	0	0	4.00
5.00	Speech Pathology	16	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	13,858	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	TELEMEDICINE	1,734	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	84,059	11,577	7,406	0	5,981	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: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	0	21,782	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	TELEMEDICINE	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	21,782	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-2 Part I Date/Time Prepared: 1/28/2013 5:25 pm

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	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	83,113	0	83,113		1.00
2.00	Skilled Nursing Care	0	258,077	0	258,077	42,515	2.00
3.00	Physical Therapy	0	111,659	0	111,659	18,395	3.00
4.00	Occupational Therapy	0	34,343	0	34,343	5,658	4.00
5.00	Speech Pathology	0	103	0	103	17	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	89,169	0	89,169	14,690	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	TELEMEDICINE	0	11,155	0	11,155	1,838	19.00
20.00	Total (sum of lines 1-19) (2)	0	587,619	0	587,619	83,113	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.					0.164741	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: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-2 Part I Date/Time Prepared: 1/28/2013 5:25 pm

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	Cost Center Description	Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	300,592		2.00
3.00	Physical Therapy	130,054		3.00
4.00	Occupational Therapy	40,001		4.00
5.00	Speech Pathology	120		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	103,859		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	TELEMEDICINE	12,993		19.00
20.00	Total (sum of lines 1-19) (2)	587,619		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,263	1,263	63,544	0	30,715	1.00
2.00	Skilled Nursing Care	0	0	157,295	0	217,968	2.00
3.00	Physical Therapy	0	0	57,603	0	94,306	3.00
4.00	Occupational Therapy	0	0	17,717	0	29,006	4.00
5.00	Speech Pathology	0	0	54	0	87	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	47,541	0	75,311	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	TELEMEDICINE	0	0	0	0	9,421	19.00
20.00	Total (sum of lines 1-19)	1,263	1,263	343,754		456,814	20.00
21.00	Total cost to be allocated	9,537	8,847	66,708		84,059	21.00
22.00	Unit cost multiplier	7.551069	7.004751	0.194057		0.184011	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

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	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	1,263	1,263	0	1,263	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	TELEMEDICINE	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,263	1,263	0	1,263	0	20.00
21.00	Total cost to be allocated	11,577	7,406	0	5,981	0	21.00
22.00	Unit cost multiplier	9.166271	5.863816	0.000000	4.735550	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2011 To 08/31/2012

Worksheet H-2 Part II Date/Time Prepared: 1/28/2013 5:25 pm

Home Health Agency I

PPS

	Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	14.00	16.00	19.00	
1.00	Administrative and General	14,210	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	TELEMEDICINE	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	14,210	0	0	0	0	20.00
21.00	Total cost to be allocated	21,782	0	0	0	0	21.00
22.00	Unit cost multiplier	1.532864	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/28/2013 5:25 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	300,592		300,592	1,977	1.00
2.00	Physical Therapy	3.00	130,054	0	130,054	1,255	2.00
3.00	Occupational Therapy	4.00	40,001	0	40,001	386	3.00
4.00	Speech Pathology	5.00	120	0	120	1	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	103,859		103,859	704	6.00
7.00	Total (sum of lines 1-6)		574,626	0	574,626	4,323	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	545	601		8.00
9.00	Physical Therapy		99914	436	300		9.00
10.00	Occupational Therapy		99914	170	134		10.00
11.00	Speech Pathology		99914	0	0		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	174	334		13.00
14.00	Total (sum of lines 8-13)			1,325	1,369		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	0	0	0	3,810	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.530279	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.258310	0	0	4.00
5.00	Cost of Drugs	73.00	0.686881	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/28/2013 5:25 pm

HHA CCN: 147622 | 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	152.04	545	601			1.00
2.00	Physical Therapy	103.63	436	300			2.00
3.00	Occupational Therapy	103.63	170	134			3.00
4.00	Speech Pathology	120.00	0	0			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	147.53	174	334			6.00
7.00	Total (sum of lines 1-6)		1,325	1,369			7.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000					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: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-3 Parts I-II Date/Time Prepared: 1/28/2013 5:25 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Cost of Services: Part A	Part B: Not Subject to Deductibles & Coinsurance	Part B: Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	82,862	91,376		174,238		1.00
2.00	Physical Therapy	45,183	31,089		76,272		2.00
3.00	Occupational Therapy	17,617	13,886		31,503		3.00
4.00	Speech Pathology	0	0		0		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	25,670	49,275		74,945		6.00
7.00	Total (sum of lines 1-6)	171,332	185,626		356,958		7.00

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

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

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140019 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/28/2013 5:25 pm

HHA CCN: 147622 | 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	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	179,571	152,030	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	3,930	5,033	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,288	2,807	13.00
14.00	Total PPS Reimbursement - PEP Episodes	996	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	53	945	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)	186,838	160,815	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	186,838	160,815	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	186,838	160,815	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)	186,838	160,815	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	186,838	160,815	31.00
32.00	Interim payments (see instructions)	186,838	160,815	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: 140019 HHA CCN: 147622 | Period: From 09/01/2011 To 08/31/2012 | Worksheet H-5 Date/Time Prepared: 1/28/2013 5:25 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		186,838		160,815	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)		186,838		160,815	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)		186,838		160,815	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140019	Period: From 09/01/2011 To 08/31/2012	Worksheet L Parts I-III Date/Time Prepared: 1/28/2013 5:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	160,657	1.00
2.00	Capital DRG outlier payments	0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	5.95	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)	160,657	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: 140019 | Component CCN: 143446 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/28/2013 5:25 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	400,255	0	400,255	0	400,255	1.00
2.00	Physician Assistant	148,243	0	148,243	0	148,243	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	88,946	0	88,946	0	88,946	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	637,444	0	637,444	0	637,444	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	19,134	19,134	0	19,134	15.00
16.00	Transportation (Health Care Staff)	0	66	66	0	66	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	3,903	3,903	0	3,903	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	23,103	23,103	0	23,103	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	637,444	23,103	660,547	0	660,547	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	866	866	0	866	29.00
30.00	Administrative Costs	103,769	5,331	109,100	35,099	144,199	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	103,769	6,197	109,966	35,099	145,065	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	741,213	29,300	770,513	35,099	805,612	32.00

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

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/28/2013 5:25 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	400,255		1.00
2.00	Physician Assistant	0	148,243		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	88,946		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	637,444		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	19,134		15.00
16.00	Transportation (Health Care Staff)	0	66		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	3,903		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	23,103		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	660,547		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	866		29.00
30.00	Administrative Costs	-794	143,405		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-794	144,271		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-794	804,818		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-2 | Date/Time Prepared: 1/28/2013 5:25 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	1.58	3,587	4,200	6,636		1.00
2.00	Physician Assistant	1.62	3,213	2,100	3,402		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	3.20	6,800		10,038	10,038	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.20	6,800			10,038	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)					660,547	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)					660,547	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)					144,271	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					539,115	15.00
16.00	Total overhead (sum of lines 14 and 15)					683,386	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					683,386	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					683,386	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,343,933	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2011 To 08/31/2012	Worksheet M-3 Date/Time Prepared: 1/28/2013 5:25 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)		1,343,933	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,123	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,336,810	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		10,038	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)		10,038	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		133.17	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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	133.17	133.17	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,685	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	357,561	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	357,561	16.00
16.01	Total program charges (see instructions)(from contractor's records)		224,440	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,450	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,496	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.)		263,429	16.04
16.05	Total program cost (see instructions)		268,925	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,779	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,642	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		268,925	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,898	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		271,823	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)		271,823	26.00
27.00	Interim payments		312,455	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)		-40,632	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-4 | Date/Time Prepared: 1/28/2013 5:25 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)	637,444	637,444	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000137	0.000682	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	87	435	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,424	1,555	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,511	1,990	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	660,547	660,547	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	683,386	683,386	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002287	0.003013	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,563	2,059	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,074	4,049	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	24	119	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	128.08	34.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	40	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,537	1,361	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)		7,123	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)		2,898	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2011 To 08/31/2012	Worksheet M-5 Date/Time Prepared: 1/28/2013 5:25 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		312,455	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		312,455	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		40,632	6.02
7.00	Total Medicare program liability (see instructions)		271,823	7.00

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