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: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 10/31/2012 7:57 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/31/2012 Time: 7:57 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [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 SPARTA COMMUNITY HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	149,978	62,671	402,783	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	103,618	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		181,321		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	253,596	243,992	402,783	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.

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 10/31/2012 7:57 am

PART I - COST REPORT STATUS

Provider use only

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Contractor use only

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   (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.

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information

ECR: Date: 10/31/2012 Time: 7:57 am
lD9FIRTZcYfOORyfr2FlvzXVJyGOP0
U1FOo04DuI4Y8EJeNkz2nEPHAUKtZb
RIvb0eaFDB0m9PP:

PI: Date: 10/31/2012 Time: 7:57 am
rMhPLvA5EC7MW3CbLviWoalIfdQ940
nxfaV0tL0rlBOuy1.fLelYkC13EhRw
SI8NUDqG2B0DoSD1

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	149,978	62,671	402,783	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	103,618	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		181,321		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	253,596	243,992	402,783	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2012 4:20 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 818 EAST BROADWAY	PO Box:			1.00
2.00	City: SPARTA	State: IL	Zip Code: 62286	County: RANDOLPH	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	SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	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	SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SPARTA COMMUNITY HHA	147694	99914		08/07/1998	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	WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	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.	0	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	Date of Geogr	
		1.00	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.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 10/30/2012 4:20 pm

		Beginning:	Ending:	
		1.00	2.00	
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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2012 4:20 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)	N	N	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

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		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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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.	Y	Y	Y	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.	643,755	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.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2012 4:20 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)						433,521	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 10/30/2012 4:20 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	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	09/17/2012	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 10/30/2012 4:20 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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
			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		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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 10/30/2012 4:20 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	09/17/2012	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2012 4:20 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	25	9,150	64,200.00		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)		25	9,150	64,200.00		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)		25	9,150	64,200.00		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)		25				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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2012 4:20 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	1,922	209	2,675		1.00
2.00	HMO		5	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	737	0	737		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	6		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,659	209	3,418		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	2,659	209	3,418		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	4,122	0	5,768		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	10,528	0	40,364		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		56	340		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				6		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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2012 4:20 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	535	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	186.93	0.00	0	535	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	8.50	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	49.38	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	244.81	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2012 4:20 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)	79	840		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)	79	840		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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141349 | Component CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-4 | Date/Time Prepared: 10/30/2012 4:20 pm

Home Health Agency I | PPS

		1.00	
0.00	County	RANDOLPH	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	56	0	0	56	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	262.00	35.00	45.00	342.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.15	0.00	2.15	5.00
6.00	Direct Nursing Service		5.05	0.00	5.05	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.27	0.98	2.25	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.15	0.15	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.05	0.05	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.03	0.00	0.03	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			41180			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,162	31	41	74	2,308	21.00
22.00	Skilled Nursing Visit Charges	472,629	6,694	9,845	16,263	505,431	22.00
23.00	Physical Therapy Visits	1,414	29	6	33	1,482	23.00
24.00	Physical Therapy Visit Charges	257,238	5,236	1,611	6,069	270,154	24.00
25.00	Occupational Therapy Visits	161	39	0	0	200	25.00
26.00	Occupational Therapy Visit Charges	29,066	6,715	0	0	35,781	26.00
27.00	Speech Pathology Visits	42	29	0	0	71	27.00
28.00	Speech Pathology Visit Charges	9,261	6,395	0	0	15,656	28.00
29.00	Medical Social Service Visits	6	0	0	0	6	29.00
30.00	Medical Social Service Visit Charges	1,909	0	0	0	1,909	30.00
31.00	Home Health Aide Visits	42	13	0	0	55	31.00
32.00	Home Health Aide Visit Charges	5,114	1,583	0	0	6,697	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,827	141	47	107	4,122	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)	775,217	26,623	11,456	22,332	835,628	35.00
36.00	Total Number of Episodes (standard/non outlier)	254		19	11	284	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	16,102	431	170	691	17,394	38.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-8 | Date/Time Prepared: 10/30/2012 4:20 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1300 NORTH MARKET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	SPARTA	IL	62286	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	13:00	17:00	11:30	19:00		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.	Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	WOMENS HEALTH CLINIC	143464	14.00
14.01		COULTERVILLE MEDICAL CLINIC	143465	14.01
14.02		FAMILY HEALTH CLINIC	143466	14.02
14.03		STEELEVILLE CLINIC	143467	14.03
14.04		MARISSA MEDICAL CLINIC	143490	14.04
14.05		SPARTA MEDICAL OFFICE	143489	14.05
14.06				14.06

		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: 141349
Component CCN: 143464

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

Worksheet S-8

Date/Time Prepared:
10/30/2012 4:20 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		RANDOLPH				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	11:30	19:00	13:00	19:00		11.00

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

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-8 | Date/Time Prepared: 10/30/2012 4:20 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	11:30	19:00	11:30	19:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 10/30/2012 4:20 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	10:00	15:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-10 | Date/Time Prepared: 10/30/2012 4:20 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)	0.461846	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,547,784	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,525,057	5.00
6.00	Medicaid charges	7,399,261	6.00
7.00	Medicaid cost (line 1 times line 6)	3,417,319	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)	344,478	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)	344,478	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	593,358	0	593,358	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	274,040	0	274,040	21.00
22.00	Partial payment by patients approved for charity care	23,048	0	23,048	22.00
23.00	Cost of charity care (line 21 minus line 22)	250,992	0	250,992	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)	1,763,700	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	445,555	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,318,145	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	608,780	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	859,772	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,204,250	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 10/30/2012 4:20 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		794,973	794,973	-19,202	775,771	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	207,815	207,815	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		817,889	817,889	20,525	838,414	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	3,253,519	3,253,519	0	3,253,519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,868,897	2,111,115	3,980,012	436,998	4,417,010	5.00
6.00	00600	MAINTENANCE & REPAIRS	195,765	6,806	202,571	0	202,571	6.00
7.00	00700	OPERATION OF PLANT	0	426,192	426,192	0	426,192	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,845	43,845	0	43,845	8.00
9.00	00900	HOUSEKEEPING	279,544	27,527	307,071	0	307,071	9.00
10.00	01000	DIETARY	234,606	148,742	383,348	0	383,348	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	126,882	12,409	139,291	0	139,291	13.00
15.00	01500	PHARMACY	0	812,401	812,401	0	812,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142,952	46,240	189,192	0	189,192	16.00
17.00	01700	SOCIAL SERVICE	29,977	618	30,595	0	30,595	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	587,569	587,569	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,140,463	304,272	1,444,735	0	1,444,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	519,698	366,397	886,095	-180,084	706,011	50.00
53.00	05300	ANESTHESIOLOGY	241,569	422,901	664,470	-636,374	28,096	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	367,636	148,580	516,216	-76,305	439,911	54.00
54.01	05401	ULTRASOUND	91,012	26,703	117,715	997	118,712	54.01
56.00	05600	RADIOISOTOPE	0	389,807	389,807	17,805	407,612	56.00
57.00	05700	CT SCAN	0	297,798	297,798	76,305	374,103	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	312,237	312,237	0	312,237	58.00
60.00	06000	LABORATORY	544,437	899,332	1,443,769	-72,875	1,370,894	60.00
65.00	06500	RESPIRATORY THERAPY	50,224	29,928	80,152	0	80,152	65.00
66.00	06600	PHYSICAL THERAPY	505,306	66,869	572,175	-509	571,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,131	5,791	24,922	54,073	78,995	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	180,084	180,084	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	376,289	376,289	0	376,289	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	100,200	100,200	0	100,200	75.01
75.02	03952	WOUND CENTER	0	48,575	48,575	0	48,575	75.02
76.00	03953	CARDIAC REHAB	68,029	6,918	74,947	0	74,947	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,041,657	1,384,608	4,426,265	-521,106	3,905,159	88.00
91.00	09100	EMERGENCY	693,754	1,062,200	1,755,954	0	1,755,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	450,349	135,061	585,410	-5,455	579,955	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		163,920	163,920	-163,920	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,611,888	15,050,662	25,662,550	-93,659	25,568,891	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,474	3,474	0	3,474	192.00
194.00	07950	FREESTANDING CLINICS	942,086	-12,608	929,478	93,659	1,023,137	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	11,553,974	15,041,528	26,595,502	0	26,595,502	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 10/30/2012 4:20 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	-64,920	710,851		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	207,815		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-72,267	766,147		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-600,617	2,652,902		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-296,798	4,120,212		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	202,571		6.00
7.00	00700	OPERATION OF PLANT	0	426,192		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,845		8.00
9.00	00900	HOUSEKEEPING	0	307,071		9.00
10.00	01000	DIETARY	-51,354	331,994		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	139,291		13.00
15.00	01500	PHARMACY	0	812,401		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-35,330	153,862		16.00
17.00	01700	SOCIAL SERVICE	0	30,595		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-587,569	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-113,151	1,331,584		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	706,011		50.00
53.00	05300	ANESTHESIOLOGY	0	28,096		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-3,570	436,341		54.00
54.01	05401	ULTRASOUND	0	118,712		54.01
56.00	05600	RADIOISOTOPE	0	407,612		56.00
57.00	05700	CT SCAN	0	374,103		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	312,237		58.00
60.00	06000	LABORATORY	0	1,370,894		60.00
65.00	06500	RESPIRATORY THERAPY	0	80,152		65.00
66.00	06600	PHYSICAL THERAPY	0	571,666		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	78,995		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	180,084		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	376,289		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	100,200		75.01
75.02	03952	WOUND CENTER	0	48,575		75.02
76.00	03953	CARDIAC REHAB	0	74,947		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-4,997	3,900,162		88.00
91.00	09100	EMERGENCY	-755,205	1,000,749		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	579,955		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,585,778	22,983,113		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,474		192.00
194.00	07950	FREESTANDING CLINICS	0	1,023,137		194.00
194.01	07951	UNUSED SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,585,778	24,009,724		200.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 10/30/2012 4:20 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS COST OF SUPPLIES SOLD					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	180,084		1.00
	TOTALS		0	180,084		
	B - TO RECLASS INTEREST EXPENSE					
1.00		0.00	0	0		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,620		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	4,300		3.00
	TOTALS		0	163,920		
	C - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	72,875	0		1.00
	TOTALS		72,875	0		
	D - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP RELATED COST	3.00	0	49,518		1.00
	TOTALS		0	49,518		
	E - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,482		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
	TOTALS		0	32,482		
	F - TO RECLASS ADMINISTRATIVE EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	341,143	119,041		1.00
2.00	FREESTANDING CLINICS	194.00	0	436,012		2.00
3.00		0.00	0	0		3.00
	TOTALS		341,143	555,053		
	G - TO RECLASS CRNA SALARIES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	241,569	346,000		1.00
	TOTALS		241,569	346,000		
	H - TO RECLASS HHA BILLER SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	4,535	0		1.00
	TOTALS		4,535	0		
	I - TO RECLASS NORTH CAMPUS DEPRECIATION					
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	202,059		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	202,059		
	J - TO RECLASS RADIOLOGY SALARIES					
1.00	CT SCAN	57.00	76,305	0		1.00
	TOTALS		76,305	0		
	K - TO RECLASS RHC RECRUITMENT EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	14,985		1.00
	TOTALS		0	14,985		
	L - TO RECLASS EKG SALARIES					
1.00	RADIOISOTOPE	56.00	17,805	0		1.00
2.00	ULTRASOUND	54.01	997	0		2.00
	TOTALS		18,802	0		
500.00	Grand Total: Increases		755,229	1,544,101		500.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 10/30/2012 4:20 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES SOLD						
1.00	OPERATING ROOM	50.00	0	180,084	0		1.00
	TOTALS		0	180,084			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	163,920	0		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	163,920			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	72,875	0	0		1.00
	TOTALS		72,875	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,518	12		1.00
	TOTALS		0	49,518			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00		0.00	0	0	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	509	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	29,843	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	920	0		4.00
5.00	FREESTANDING CLINICS	194.00	0	1,210	0		5.00
	TOTALS		0	32,482			
	F - TO RECLASS ADMINISTRATIVE EXPENSES						
1.00	ANESTHESIOLOGY	53.00	0	48,805	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	506,248	0		2.00
3.00	FREESTANDING CLINICS	194.00	341,143	0	0		3.00
	TOTALS		341,143	555,053			
	G - TO RECLASS CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	241,569	346,000	0		1.00
	TOTALS		241,569	346,000			
	H - TO RECLASS HHA BILLER SALARIES						
1.00	HOME HEALTH AGENCY	101.00	4,535	0	0		1.00
	TOTALS		4,535	0			
	I - TO RECLASS NORTH CAMPUS DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	202,059	9		2.00
	TOTALS		0	202,059			
	J - TO RECLASS RADIOLOGY SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	76,305	0	0		1.00
	TOTALS		76,305	0			
	K - TO RECLASS RHC RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,985	0		1.00
	TOTALS		0	14,985			
	L - TO RECLASS EKG SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	18,802	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		18,802	0			
500.00	Grand Total: Decreases		755,229	1,544,101			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 10/30/2012 4:20 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	179,834	0	0	0	0	1.00
2.00	Land Improvements	663,393	5,886	0	5,886	0	2.00
3.00	Buildings and Fixtures	15,393,277	183,967	0	183,967	1,785	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,601,383	812,928	0	812,928	347,665	6.00
7.00	HIT designated Assets	0	433,521	0	433,521	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,837,887	1,436,302	0	1,436,302	349,450	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,837,887	1,436,302	0	1,436,302	349,450	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	794,973	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	817,889	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,612,862	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	13,019,751	0	13,019,751	0.469266	23,237	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,224,987	0	3,224,987	0.116237	5,756	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,500,167	0	11,500,167	0.414497	20,525	2.00
3.00	Total (sum of lines 1-2)	27,744,905	0	27,744,905	1.000000	49,518	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 10/30/2012 4:20 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	179,834	0				1.00
2.00	Land Improvements	669,279	0				2.00
3.00	Buildings and Fixtures	15,575,459	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	11,066,646	0				6.00
7.00	HIT designated Assets	433,521	0				7.00
8.00	Subtotal (sum of lines 1-7)	27,924,739	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	27,924,739	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	0	794,973				1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	817,889				2.00
3.00	Total (sum of lines 1-2)	0	1,612,862				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	0	0	23,237	592,914	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	5,756	202,059	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,525	745,622	0	2.00
3.00	Total (sum of lines 1-2)	0	0	49,518	1,540,595	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 10/30/2012 4:20 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	94,700	23,237	0	0	710,851	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	5,756	0	0	207,815	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,525	0	0	766,147	2.00
3.00	Total (sum of lines 1-2)	94,700	49,518	0	0	1,684,813	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 10/30/2012 4:20 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	-64,920	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	1.01
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	-1,747	ADMINISTRATIVE & GENERAL	5.00	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)	B	-39,847	ADMINISTRATIVE & GENERAL	5.00	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	-876,923			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	-51,354	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-30	ADMINISTRATIVE & GENERAL	5.00	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	-35,330	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
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist	A	-587,569	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-71,381	CAP REL COSTS-MVBLE EQUIP	2.00	32.00
33.00	BILL COPY CHARGES	B	-7,733	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	MISCELLANEOUS INCOME	B	-60,785	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	TRANSMED SERVICE REVENUE	B	-3,380	ADMINISTRATIVE & GENERAL	5.00	33.02
33.04	PERSONAL USE OF AUTO	A	-17,181	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	CRNA BENEFITS	A	-28,026	EMPLOYEE BENEFITS	4.00	33.05
33.06	MARKETING SALARY	A	-32,809	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	MARKETING EXPENSES	A	-105,962	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-15,686	EMPLOYEE BENEFITS	4.00	33.08
33.09	MARKETING CAPITAL EXPENSE	A	-886	CAP REL COSTS-MVBLE EQUIP	2.00	33.09
33.10	LOBBYING EXPENSES	A	-7,973	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	SELF INSURANCE EXPENSE	A	-492,399	EMPLOYEE BENEFITS	4.00	33.11
33.12	VOLUNTARY HOSPITAL CONTRIBUTION	A	-16,467	ADMINISTRATIVE & GENERAL	5.00	33.12
33.14	FINES & PENALTIES	A	-2,884	ADMINISTRATIVE & GENERAL	5.00	33.14
33.15	PHYSICIAN EMPLOYEE BENEFITS	A	-1,027	EMPLOYEE BENEFITS	4.00	33.15
33.16	RHC SELF INSURANCE EXPENSE	A	-63,479	EMPLOYEE BENEFITS	4.00	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,585,778			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 10/30/2012 4:20 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11		1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)	0		1.01
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
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG	0		26.01
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	9		32.00
33.00	BILL COPY CHARGES	0		33.00
33.01	MISCELLANEOUS INCOME	0		33.01
33.02	TRANSMED SERVICE REVENUE	0		33.02
33.04	PERSONAL USE OF AUTO	0		33.04
33.05	CRNA BENEFITS	0		33.05
33.06	MARKETING SALARY	0		33.06
33.07	MARKETING EXPENSES	0		33.07
33.08	MARKETING EMPLOYEE BENEFITS	0		33.08
33.09	MARKETING CAPITAL EXPENSE	9		33.09
33.10	LOBBYING EXPENSES	0		33.10
33.11	SELF INSURANCE EXPENSE	0		33.11
33.12	VOLUNTARY HOSPITAL CONTRIBUTION	0		33.12
33.14	FINES & PENALTIES	0		33.14
33.15	PHYSICIAN EMPLOYEE BENEFITS	0		33.15
33.16	RHC SELF INSURANCE EXPENSE	0		33.16
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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2012 4:20 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	113,151	113,151	1.00
2.00		91.00	EMERGENCY	923,798	755,205	2.00
3.00		54.00	RADIOLOGY - DIAGNOSTIC	3,570	3,570	3.00
4.00		60.00	LABORATORY	20,200	0	4.00
5.00		88.00	RURAL HEALTH CLINIC	4,997	4,997	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				1,065,716	876,923	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2012 4:20 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		168,593	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		20,200	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		188,793		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2012 4:20 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2012 4:20 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	113,151		1.00
2.00		0	755,205		2.00
3.00		0	3,570		3.00
4.00		0	0		4.00
5.00		0	4,997		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	876,923		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 10/30/2012 4:20 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					2	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	13.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.57	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					962	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					962	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					962	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.60	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					1,089	22.00
23.00	Total salary equivalency (see instructions)					1,089	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					73	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					73	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					12	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					85	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					85	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 10/30/2012 4:20 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.57	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	1,089	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	85	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	1,174	63.00
64.00	Total cost of outside supplier services (from your records)	795	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	73	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	12	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	85	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	12	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	12	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		3	1.00
2.00	Line 1 multiplied by 15 hours per week		45	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.85	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4.50	13.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	92.87	68.79	51.59	34.40	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.40	34.40	25.80			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	310	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	671	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	981	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	981	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	56.06	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	2,523	22.00
23.00	Total salary equivalency (see instructions)	2,523	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	103	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	103	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	18	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	121	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	121	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 10/30/2012 4:20 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.79	51.59	34.40	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	2,523	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	121	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	2,644	63.00
64.00	Total cost of outside supplier services (from your records)	855	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	103	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	18	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	121	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	18	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	18	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 10/30/2012 4:20 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					12	1.00
2.00	Line 1 multiplied by 15 hours per week					180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					21	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	260.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.10	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.05	33.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					17,236	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					17,236	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					17,236	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					17,236	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					694	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					694	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					123	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					817	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					817	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 10/30/2012 4:20 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.10	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	17,236		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	817		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	18,053		63.00
64.00	Total cost of outside supplier services (from your records)	15,825		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	694		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	123		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	817		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	123		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	123		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	EMPLOYEE BENEFITS	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	710,851	710,851				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	207,815	0	207,815			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	766,147			766,147		2.00
4.00	00400	EMPLOYEE BENEFITS	2,652,902	0	0	0	2,652,902	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,120,212	89,301	0	113,320	513,367	5.00
6.00	00600	MAINTENANCE & REPAIRS	202,571	16,849	0	389	46,063	6.00
7.00	00700	OPERATION OF PLANT	426,192	40,940	0	53,727	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,845	8,090	0	0	0	8.00
9.00	00900	HOUSEKEEPING	307,071	6,731	0	588	65,776	9.00
10.00	01000	DIETARY	331,994	16,265	0	7,997	55,203	10.00
11.00	01100	CAFETERIA	0	9,778	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	139,291	5,245	0	459	29,855	13.00
15.00	01500	PHARMACY	812,401	5,372	0	3,065	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,862	3,854	0	3,730	33,636	16.00
17.00	01700	SOCIAL SERVICE	30,595	0	0	0	7,054	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,331,584	77,112	0	53,512	268,350	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	706,011	72,579	0	164,140	122,284	50.00
53.00	05300	ANESTHESIOLOGY	28,096	924	0	10,177	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	436,341	21,638	0	140,792	68,550	54.00
54.01	05401	ULTRASOUND	118,712	4,608	0	12,099	21,650	54.01
56.00	05600	RADIOISOTOPE	407,612	4,937	0	0	4,189	56.00
57.00	05700	CT SCAN	374,103	4,141	0	498	17,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,237	0	0	0	0	58.00
60.00	06000	LABORATORY	1,370,894	17,242	0	47,081	110,958	60.00
65.00	06500	RESPIRATORY THERAPY	80,152	1,784	0	6,577	11,818	65.00
66.00	06600	PHYSICAL THERAPY	571,666	11,966	136,184	26,392	118,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,995	5,096	0	3,840	17,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	180,084	11,445	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	376,289	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	100,200	4,459	0	1,469	0	75.01
75.02	03952	WOUND CENTER	48,575	2,739	0	0	0	75.02
76.00	03953	CARDIAC REHAB	74,947	22,986	0	7,438	16,007	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,900,162	163,167	71,631	44,667	714,524	88.00
91.00	09100	EMERGENCY	1,000,749	40,133	0	21,994	163,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	579,955	15,225	0	14,060	104,900	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,983,113	684,606	207,815	738,011	2,511,501	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,123	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,474	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	1,023,137	21,786	0	28,136	141,401	194.00
194.01	07951	UNUSED SPACE	0	2,336	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,009,724	710,851	207,815	766,147	2,652,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,836,200	4,836,200				5.00
6.00	00600	MAINTENANCE & REPAIRS	265,872	67,062	332,934			6.00
7.00	00700	OPERATION OF PLANT	520,859	131,378	16,184	668,421		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,935	13,100	3,198	16,006	84,239	8.00
9.00	00900	HOUSEKEEPING	380,166	95,890	2,661	13,317	337	9.00
10.00	01000	DIETARY	411,459	103,784	6,430	32,180	865	10.00
11.00	01100	CAFETERIA	9,778	2,466	3,865	19,346	0	11.00
13.00	01300	NURSING ADMINISTRATION	174,850	44,103	2,073	10,376	0	13.00
15.00	01500	PHARMACY	820,838	207,042	2,124	10,629	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,082	49,206	1,524	7,625	0	16.00
17.00	01700	SOCIAL SERVICE	37,649	9,496	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,730,558	436,504	30,483	152,560	46,396	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,065,014	268,632	28,691	143,590	9,259	50.00
53.00	05300	ANESTHESIOLOGY	39,197	9,887	365	1,827	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	667,321	168,320	8,554	42,808	4,149	54.00
54.01	05401	ULTRASOUND	157,069	39,618	1,822	9,116	2,409	54.01
56.00	05600	RADIOISOTOPE	416,738	105,115	1,952	9,767	185	56.00
57.00	05700	CT SCAN	396,696	100,060	1,637	8,192	1,162	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,237	78,756	0	0	0	58.00
60.00	06000	LABORATORY	1,546,175	389,996	6,816	34,112	0	60.00
65.00	06500	RESPIRATORY THERAPY	100,331	25,307	705	3,529	0	65.00
66.00	06600	PHYSICAL THERAPY	865,106	218,208	66,259	23,673	5,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	105,156	26,524	2,015	10,082	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	191,529	48,310	4,524	22,643	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	376,289	94,913	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	106,128	26,769	1,763	8,822	0	75.01
75.02	03952	WOUND CENTER	51,314	12,943	1,083	0	0	75.02
76.00	03953	CARDIAC REHAB	121,378	30,616	9,087	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,894,151	1,234,471	96,861	0	595	88.00
91.00	09100	EMERGENCY	1,226,116	309,267	15,865	79,399	13,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	714,140	180,130	6,019	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,787,331	4,527,873	322,560	659,599	84,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,123	535	839	4,201	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,474	876	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	1,214,460	306,327	8,612	0	140	194.00
194.01	07951	UNUSED SPACE	2,336	589	923	4,621	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,009,724	4,836,200	332,934	668,421	84,239	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	492,371					9.00
10.00	01000	DIETARY	8,104	562,822				10.00
11.00	01100	CAFETERIA	14,775	420,117	470,347			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,358	238,760		13.00
15.00	01500	PHARMACY	2,370	0	0	0	1,043,003	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,865	0	29,431	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	5,137	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	204,158	142,705	141,882	129,716	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,794	0	50,950	45,439	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	19,070	0	31,236	0	0	54.00
54.01	05401	ULTRASOUND	7,841	0	8,052	0	0	54.01
56.00	05600	RADIOISOTOPE	784	0	1,249	0	0	56.00
57.00	05700	CT SCAN	5,342	0	8,746	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	24,254	0	60,390	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,414	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,383	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,043,003	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	53	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,090	0	23,739	0	0	88.00
91.00	09100	EMERGENCY	81,716	0	70,247	63,605	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	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)	491,599	562,822	443,831	238,760	1,043,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	772	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0	26,516	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	492,371	562,822	470,347	238,760	1,043,003	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	291,733					16.00
17.00	01700	SOCIAL SERVICE	0	52,282				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,433	52,282	0	3,110,677	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,894	0	0	1,737,263	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	51,276	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	64,847	0	0	1,006,305	0	54.00
54.01	05401	ULTRASOUND	13,364	0	0	239,291	0	54.01
56.00	05600	RADIOISOTOPE	2,734	0	0	538,524	0	56.00
57.00	05700	CT SCAN	18,072	0	0	539,907	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	390,993	0	58.00
60.00	06000	LABORATORY	41,915	0	0	2,103,658	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	135,286	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,178,249	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	149,160	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	267,006	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	471,202	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,043,003	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	143,482	0	75.01
75.02	03952	WOUND CENTER	0	0	0	65,393	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	161,081	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	46,015	0	0	6,298,922	0	88.00
91.00	09100	EMERGENCY	41,459	0	0	1,901,413	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	900,289	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	291,733	52,282	0	22,432,380	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	7,698	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	5,122	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0	0	1,556,055	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	8,469	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	291,733	52,282	0	24,009,724	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,110,677		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,737,263		50.00
53.00	05300	ANESTHESIOLOGY	51,276		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,006,305		54.00
54.01	05401	ULTRASOUND	239,291		54.01
56.00	05600	RADIOISOTOPE	538,524		56.00
57.00	05700	CT SCAN	539,907		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,993		58.00
60.00	06000	LABORATORY	2,103,658		60.00
65.00	06500	RESPIRATORY THERAPY	135,286		65.00
66.00	06600	PHYSICAL THERAPY	1,178,249		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	149,160		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,006		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	471,202		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,003		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	143,482		75.01
75.02	03952	WOUND CENTER	65,393		75.02
76.00	03953	CARDIAC REHAB	161,081		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	6,298,922		88.00
91.00	09100	EMERGENCY	1,901,413		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	900,289		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,432,380		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,698		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,122		192.00
194.00	07950	FREESTANDING CLINICS	1,556,055		194.00
194.01	07951	UNUSED SPACE	8,469		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	24,009,724		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	78,742	89,301	0	113,320	281,363	5.00
6.00	00600	MAINTENANCE & REPAIRS	259	16,849	0	389	17,497	6.00
7.00	00700	OPERATION OF PLANT	0	40,940	0	53,727	94,667	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,090	0	0	8,090	8.00
9.00	00900	HOUSEKEEPING	0	6,731	0	588	7,319	9.00
10.00	01000	DIETARY	0	16,265	0	7,997	24,262	10.00
11.00	01100	CAFETERIA	0	9,778	0	0	9,778	11.00
13.00	01300	NURSING ADMINISTRATION	10	5,245	0	459	5,714	13.00
15.00	01500	PHARMACY	6,804	5,372	0	3,065	15,241	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,854	0	3,730	7,584	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,557	77,112	0	53,512	163,181	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,863	72,579	0	164,140	253,582	50.00
53.00	05300	ANESTHESIOLOGY	96	924	0	10,177	11,197	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	16,834	21,638	0	140,792	179,264	54.00
54.01	05401	ULTRASOUND	32	4,608	0	12,099	16,739	54.01
56.00	05600	RADIOISOTOPE	0	4,937	0	0	4,937	56.00
57.00	05700	CT SCAN	139,336	4,141	0	498	143,975	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,242	0	47,081	64,323	60.00
65.00	06500	RESPIRATORY THERAPY	15,737	1,784	0	6,577	24,098	65.00
66.00	06600	PHYSICAL THERAPY	0	11,966	136,184	26,392	174,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,096	0	3,840	8,936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,445	0	0	11,445	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	4,459	0	1,469	5,928	75.01
75.02	03952	WOUND CENTER	0	2,739	0	0	2,739	75.02
76.00	03953	CARDIAC REHAB	0	22,986	0	7,438	30,424	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,511	163,167	71,631	44,667	293,976	88.00
91.00	09100	EMERGENCY	0	40,133	0	21,994	62,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,225	0	14,060	29,285	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	321,781	684,606	207,815	738,011	1,952,213	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,123	0	0	2,123	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	178	21,786	0	28,136	50,100	194.00
194.01	07951	UNUSED SPACE	0	2,336	0	0	2,336	194.01
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)	321,959	710,851	207,815	766,147	2,006,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	281,363				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,902	21,399			6.00
7.00	00700	OPERATION OF PLANT	0	7,644	1,040	103,351		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	762	206	2,475	11,533	8.00
9.00	00900	HOUSEKEEPING	0	5,579	171	2,059	46	9.00
10.00	01000	DIETARY	0	6,038	413	4,976	118	10.00
11.00	01100	CAFETERIA	0	143	248	2,991	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,566	133	1,604	0	13.00
15.00	01500	PHARMACY	0	12,046	136	1,643	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,863	98	1,179	0	16.00
17.00	01700	SOCIAL SERVICE	0	552	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,396	1,959	23,587	6,353	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,629	1,844	22,202	1,268	50.00
53.00	05300	ANESTHESIOLOGY	0	575	23	283	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	9,793	550	6,619	568	54.00
54.01	05401	ULTRASOUND	0	2,305	117	1,410	330	54.01
56.00	05600	RADIOISOTOPE	0	6,116	125	1,510	25	56.00
57.00	05700	CT SCAN	0	5,822	105	1,267	159	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,582	0	0	0	58.00
60.00	06000	LABORATORY	0	22,690	438	5,274	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,472	45	546	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,695	4,259	3,660	685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,543	129	1,559	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,811	291	3,501	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,522	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	1,557	113	1,364	0	75.01
75.02	03952	WOUND CENTER	0	753	70	0	0	75.02
76.00	03953	CARDIAC REHAB	0	1,781	584	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	71,815	6,228	0	81	88.00
91.00	09100	EMERGENCY	0	17,993	1,020	12,277	1,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	10,480	387	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	263,425	20,732	101,986	11,514	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	31	54	650	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	0	17,822	554	0	19	194.00
194.01	07951	UNUSED SPACE	0	34	59	715	0	194.01
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)	0	281,363	21,399	103,351	11,533	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	15,174					9.00
10.00	01000	DIETARY	250	36,057				10.00
11.00	01100	CAFETERIA	455	26,915	40,530			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	634	10,651		13.00
15.00	01500	PHARMACY	73	0	0	0	29,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	273	0	2,536	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	443	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,292	9,142	12,224	5,787	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,260	0	4,390	2,027	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	588	0	2,692	0	0	54.00
54.01	05401	ULTRASOUND	242	0	694	0	0	54.01
56.00	05600	RADIOISOTOPE	24	0	108	0	0	56.00
57.00	05700	CT SCAN	165	0	754	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	747	0	5,204	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	467	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	166	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	29,139	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	2	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	95	0	2,046	0	0	88.00
91.00	09100	EMERGENCY	2,518	0	6,053	2,837	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	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)	15,150	36,057	38,245	10,651	29,139	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0	2,285	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	15,174	36,057	40,530	10,651	29,139	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,533					16.00
17.00	01700	SOCIAL SERVICE	0	995				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,164	995		257,080	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	991	0		305,193	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		12,078	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,231	0		203,305	0	54.00
54.01	05401	ULTRASOUND	666	0		22,503	0	54.01
56.00	05600	RADIOISOTOPE	136	0		12,981	0	56.00
57.00	05700	CT SCAN	900	0		153,147	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		4,582	0	58.00
60.00	06000	LABORATORY	2,088	0		100,764	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		26,628	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		195,841	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		12,333	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		18,048	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		5,522	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		29,139	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	0	0		8,962	0	75.01
75.02	03952	WOUND CENTER	0	0		3,564	0	75.02
76.00	03953	CARDIAC REHAB	0	0		32,789	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,292	0		376,533	0	88.00
91.00	09100	EMERGENCY	2,065	0		108,771	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		40,152	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,533	995	0	1,929,915	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		2,858	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		75	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0		70,780	0	194.00
194.01	07951	UNUSED SPACE	0	0		3,144	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,533	995	0	2,006,772	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
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
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	257,080		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	305,193		50.00
53.00	05300	ANESTHESIOLOGY	12,078		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	203,305		54.00
54.01	05401	ULTRASOUND	22,503		54.01
56.00	05600	RADIOISOTOPE	12,981		56.00
57.00	05700	CT SCAN	153,147		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,582		58.00
60.00	06000	LABORATORY	100,764		60.00
65.00	06500	RESPIRATORY THERAPY	26,628		65.00
66.00	06600	PHYSICAL THERAPY	195,841		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	12,333		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,048		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,522		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,139		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	8,962		75.01
75.02	03952	WOUND CENTER	3,564		75.02
76.00	03953	CARDIAC REHAB	32,789		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	376,533		88.00
91.00	09100	EMERGENCY	108,771		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	40,152		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,929,915		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,858		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75		192.00
194.00	07950	FREESTANDING CLINICS	70,780		194.00
194.01	07951	UNUSED SPACE	3,144		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,006,772		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	66,953					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	22,371				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			745,622			2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	11,274,599		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,411	0	110,284	2,181,766	-4,836,200	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,587	0	379	195,765	0	6.00
7.00	00700	OPERATION OF PLANT	3,856	0	52,288	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	762	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	634	0	572	279,544	0	9.00
10.00	01000	DIETARY	1,532	0	7,783	234,606	0	10.00
11.00	01100	CAFETERIA	921	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	494	0	447	126,882	0	13.00
15.00	01500	PHARMACY	506	0	2,983	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363	0	3,630	142,952	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	29,977	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,263	0	52,078	1,140,463	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,836	0	159,742	519,698	0	50.00
53.00	05300	ANESTHESIOLOGY	87	0	9,904	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,038	0	137,020	291,331	0	54.00
54.01	05401	ULTRASOUND	434	0	11,775	92,009	0	54.01
56.00	05600	RADIOISOTOPE	465	0	0	17,805	0	56.00
57.00	05700	CT SCAN	390	0	485	76,305	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,624	0	45,820	471,562	0	60.00
65.00	06500	RESPIRATORY THERAPY	168	0	6,401	50,224	0	65.00
66.00	06600	PHYSICAL THERAPY	1,127	14,660	25,685	505,306	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	480	0	3,737	73,204	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,078	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	420	0	1,430	0	0	75.01
75.02	03952	WOUND CENTER	258	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	2,165	0	7,239	68,029	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,368	7,711	43,470	3,036,660	0	88.00
91.00	09100	EMERGENCY	3,780	0	21,405	693,754	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,434	0	13,683	445,814	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,481	22,371	718,240	10,673,656	-4,836,200	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	2,052	0	27,382	600,943	0	194.00
194.01	07951	UNUSED SPACE	220	0	0	0	0	194.01
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)	710,851	207,815	766,147	2,652,902		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.617164	9.289482	1.027527	0.235299		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,173,524					5.00
6.00	00600	MAINTENANCE & REPAIRS	265,872	79,326				6.00
7.00	00700	OPERATION OF PLANT	520,859	3,856	31,822			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,935	762	762	15,003		8.00
9.00	00900	HOUSEKEEPING	380,166	634	634	60	84,145	9.00
10.00	01000	DIETARY	411,459	1,532	1,532	154	1,385	10.00
11.00	01100	CAFETERIA	9,778	921	921	0	2,525	11.00
13.00	01300	NURSING ADMINISTRATION	174,850	494	494	0	0	13.00
15.00	01500	PHARMACY	820,838	506	506	0	405	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,082	363	363	0	1,515	16.00
17.00	01700	SOCIAL SERVICE	37,649	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,730,558	7,263	7,263	8,263	34,890	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,065,014	6,836	6,836	1,649	18,080	50.00
53.00	05300	ANESTHESIOLOGY	39,197	87	87	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	667,321	2,038	2,038	739	3,259	54.00
54.01	05401	ULTRASOUND	157,069	434	434	429	1,340	54.01
56.00	05600	RADIOISOTOPE	416,738	465	465	33	134	56.00
57.00	05700	CT SCAN	396,696	390	390	207	913	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,237	0	0	0	0	58.00
60.00	06000	LABORATORY	1,546,175	1,624	1,624	0	4,145	60.00
65.00	06500	RESPIRATORY THERAPY	100,331	168	168	0	0	65.00
66.00	06600	PHYSICAL THERAPY	865,106	15,787	1,127	891	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	105,156	480	480	0	920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	191,529	1,078	1,078	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	376,289	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	106,128	420	420	0	0	75.01
75.02	03952	WOUND CENTER	51,314	258	0	0	9	75.02
76.00	03953	CARDIAC REHAB	121,378	2,165	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,894,151	23,079	0	106	528	88.00
91.00	09100	EMERGENCY	1,226,116	3,780	3,780	2,447	13,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	714,140	1,434	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,951,131	76,854	31,402	14,978	84,013	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,123	200	200	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,474	0	0	0	132	192.00
194.00	07950	FREESTANDING CLINICS	1,214,460	2,052	0	25	0	194.00
194.01	07951	UNUSED SPACE	2,336	220	220	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,836,200	332,934	668,421	84,239	492,371	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.252233	4.197035	21.004997	5.614810	5.851459	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	281,363	21,399	103,351	11,533	15,174	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014675	0.269760	3.247785	0.768713	0.180332	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
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	45,809					10.00
11.00	01100	CAFETERIA	34,194	3,388				11.00
13.00	01300	NURSING ADMINISTRATION	0	53	108,837			13.00
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	212	0	0	1,921	16.00
17.00	01700	SOCIAL SERVICE	0	37	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,615	1,022	59,130	0	286	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	367	20,713	0	131	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	225	0	0	427	54.00
54.01	05401	ULTRASOUND	0	58	0	0	88	54.01
56.00	05600	RADIOISOTOPE	0	9	0	0	18	56.00
57.00	05700	CT SCAN	0	63	0	0	119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	435	0	0	276	60.00
65.00	06500	RESPIRATORY THERAPY	0	39	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	171	0	0	303	88.00
91.00	09100	EMERGENCY	0	506	28,994	0	273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	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)	45,809	3,197	108,837	100	1,921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	0	191	0	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	562,822	470,347	238,760	1,043,003	291,733	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.286276	138.827332	2.193739	10,430.030000	151.865174	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,057	40,530	10,651	29,139	14,533	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.787116	11.962810	0.097862	291.390000	7.565331	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 10/30/2012 4:20 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG				1.01
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	3,418			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,418			30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,418	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	FREESTANDING CLINICS	0	0		194.00
194.01	07951	UNUSED SPACE	0	0		194.01
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)	52,282	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.296080	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	995	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.291106	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,110,677		3,110,677	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,737,263		1,737,263	0	0	50.00
53.00	05300	ANESTHESIOLOGY	51,276		51,276	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,006,305		1,006,305	0	0	54.00
54.01	05401	ULTRASOUND	239,291		239,291	0	0	54.01
56.00	05600	RADIOISOTOPE	538,524		538,524	0	0	56.00
57.00	05700	CT SCAN	539,907		539,907	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,993		390,993	0	0	58.00
60.00	06000	LABORATORY	2,103,658		2,103,658	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	135,286	0	135,286	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,178,249	0	1,178,249	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	149,160		149,160	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,006		267,006	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	471,202		471,202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,003		1,043,003	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	143,482		143,482	0	0	75.01
75.02	03952	WOUND CENTER	65,393		65,393	0	0	75.02
76.00	03953	CARDIAC REHAB	161,081		161,081	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,298,922		6,298,922	0	0	88.00
91.00	09100	EMERGENCY	1,901,413		1,901,413	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	281,819		281,819		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	900,289		900,289		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,714,199	0	22,714,199	0	0	200.00
201.00		Less Observation Beds	281,819		281,819		0	201.00
202.00		Total (see instructions)	22,432,380	0	22,432,380	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,477,827		1,477,827			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	483,435	3,111,418	3,594,853	0.483264	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	22,369	221,343	243,712	0.210396	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	132,886	2,319,005	2,451,891	0.410420	0.000000	54.00
54.01	05401	ULTRASOUND	314,035	1,871,065	2,185,100	0.109510	0.000000	54.01
56.00	05600	RADIOISOTOPE	151,412	1,269,966	1,421,378	0.378875	0.000000	56.00
57.00	05700	CT SCAN	565,938	7,206,618	7,772,556	0.069463	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,542	1,713,574	1,805,116	0.216603	0.000000	58.00
60.00	06000	LABORATORY	1,147,183	7,051,140	8,198,323	0.256596	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	160,747	152,240	312,987	0.432242	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	400,553	3,384,370	3,784,923	0.311301	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	44,603	348,665	393,268	0.379283	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,005	448,959	601,964	0.443558	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	439,318	350,858	790,176	0.596325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,006,166	1,619,365	3,625,531	0.287683	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	0	482,719	482,719	0.297237	0.000000	75.01
75.02	03952	WOUND CENTER	12,279	92,325	104,604	0.625148	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	154,254	154,254	1.044258	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,598,472	4,598,472			88.00
91.00	09100	EMERGENCY	85,715	3,755,829	3,841,544	0.494961	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,610	192,340	199,950	1.409447	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,140,161	1,140,161			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,696,623	41,484,686	49,181,309			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,696,623	41,484,686	49,181,309			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		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
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	75.00
75.01	03951	SLEEP LAB	0.000000	75.01
75.02	03952	WOUND CENTER	0.000000	75.02
76.00	03953	CARDIAC REHAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 pm

Title XIX | Hospital

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,110,677		3,110,677	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,737,263		1,737,263	0	0	50.00
53.00	05300	ANESTHESIOLOGY	51,276		51,276	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,006,305		1,006,305	0	0	54.00
54.01	05401	ULTRASOUND	239,291		239,291	0	0	54.01
56.00	05600	RADIOISOTOPE	538,524		538,524	0	0	56.00
57.00	05700	CT SCAN	539,907		539,907	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	390,993		390,993	0	0	58.00
60.00	06000	LABORATORY	2,103,658		2,103,658	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	135,286	0	135,286	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,178,249	0	1,178,249	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	149,160		149,160	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,006		267,006	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	471,202		471,202	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,043,003		1,043,003	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	143,482		143,482	0	0	75.01
75.02	03952	WOUND CENTER	65,393		65,393	0	0	75.02
76.00	03953	CARDIAC REHAB	161,081		161,081	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,298,922		6,298,922	0	0	88.00
91.00	09100	EMERGENCY	1,901,413		1,901,413	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	281,819		281,819		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	900,289		900,289		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,714,199	0	22,714,199	0	0	200.00
201.00		Less Observation Beds	281,819		281,819		0	201.00
202.00		Total (see instructions)	22,432,380	0	22,432,380	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 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	1,477,827		1,477,827			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	483,435	3,111,418	3,594,853	0.483264	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	22,369	221,343	243,712	0.210396	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	132,886	2,319,005	2,451,891	0.410420	0.000000	54.00
54.01	05401	ULTRASOUND	314,035	1,871,065	2,185,100	0.109510	0.000000	54.01
56.00	05600	RADIOISOTOPE	151,412	1,269,966	1,421,378	0.378875	0.000000	56.00
57.00	05700	CT SCAN	565,938	7,206,618	7,772,556	0.069463	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,542	1,713,574	1,805,116	0.216603	0.000000	58.00
60.00	06000	LABORATORY	1,147,183	7,051,140	8,198,323	0.256596	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	160,747	152,240	312,987	0.432242	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	400,553	3,384,370	3,784,923	0.311301	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	44,603	348,665	393,268	0.379283	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,005	448,959	601,964	0.443558	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	439,318	350,858	790,176	0.596325	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,006,166	1,619,365	3,625,531	0.287683	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	0	482,719	482,719	0.297237	0.000000	75.01
75.02	03952	WOUND CENTER	12,279	92,325	104,604	0.625148	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	154,254	154,254	1.044258	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,598,472	4,598,472	1.369786	0.000000	88.00
91.00	09100	EMERGENCY	85,715	3,755,829	3,841,544	0.494961	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,610	192,340	199,950	1.409447	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,140,161	1,140,161			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,696,623	41,484,686	49,181,309			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,696,623	41,484,686	49,181,309			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 10/30/2012 4:20 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
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		75.00
75.01	03951	SLEEP LAB	0.000000		75.01
75.02	03952	WOUND CENTER	0.000000		75.02
76.00	03953	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305,193	3,594,853	0.084897	261,665	22,215	50.00
53.00	05300	ANESTHESIOLOGY	12,078	243,712	0.049558	10,720	531	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	203,305	2,451,891	0.082918	86,720	7,191	54.00
54.01	05401	ULTRASOUND	22,503	2,185,100	0.010298	227,863	2,347	54.01
56.00	05600	RADIOISOTOPE	12,981	1,421,378	0.009133	92,042	841	56.00
57.00	05700	CT SCAN	153,147	7,772,556	0.019704	339,172	6,683	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,582	1,805,116	0.002538	52,753	134	58.00
60.00	06000	LABORATORY	100,764	8,198,323	0.012291	783,961	9,636	60.00
65.00	06500	RESPIRATORY THERAPY	26,628	312,987	0.085077	104,962	8,930	65.00
66.00	06600	PHYSICAL THERAPY	195,841	3,784,923	0.051742	151,898	7,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,333	393,268	0.031360	29,524	926	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,048	601,964	0.029982	104,998	3,148	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,522	790,176	0.006988	329,636	2,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,139	3,625,531	0.008037	1,195,673	9,610	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	8,962	482,719	0.018566	0	0	75.01
75.02	03952	WOUND CENTER	3,564	104,604	0.034071	0	0	75.02
76.00	03953	CARDIAC REHAB	32,789	154,254	0.212565	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	376,533	4,598,472	0.081882	0	0	88.00
91.00	09100	EMERGENCY	108,771	3,841,544	0.028314	500	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	199,950	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,632,683	46,563,321		3,772,087	82,369	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,594,853	0.000000	0.000000	261,665	50.00
53.00	05300	ANESTHESIOLOGY	0	243,712	0.000000	0.000000	10,720	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,451,891	0.000000	0.000000	86,720	54.00
54.01	05401	ULTRASOUND	0	2,185,100	0.000000	0.000000	227,863	54.01
56.00	05600	RADIOISOTOPE	0	1,421,378	0.000000	0.000000	92,042	56.00
57.00	05700	CT SCAN	0	7,772,556	0.000000	0.000000	339,172	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,805,116	0.000000	0.000000	52,753	58.00
60.00	06000	LABORATORY	0	8,198,323	0.000000	0.000000	783,961	60.00
65.00	06500	RESPIRATORY THERAPY	0	312,987	0.000000	0.000000	104,962	65.00
66.00	06600	PHYSICAL THERAPY	0	3,784,923	0.000000	0.000000	151,898	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	393,268	0.000000	0.000000	29,524	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	601,964	0.000000	0.000000	104,998	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	790,176	0.000000	0.000000	329,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,625,531	0.000000	0.000000	1,195,673	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	75.00
75.01	03951	SLEEP LAB	0	482,719	0.000000	0.000000	0	75.01
75.02	03952	WOUND CENTER	0	104,604	0.000000	0.000000	0	75.02
76.00	03953	CARDIAC REHAB	0	154,254	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,598,472	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	3,841,544	0.000000	0.000000	500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	199,950	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	46,563,321			3,772,087	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.483264	0	1,002,768	0		50.00
53.00	05300	ANESTHESIOLOGY	0.210396	0	22,286	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.410420	0	840,001	0		54.00
54.01	05401	ULTRASOUND	0.109510	0	703,643	0		54.01
56.00	05600	RADIOISOTOPE	0.378875	0	664,752	0		56.00
57.00	05700	CT SCAN	0.069463	0	2,575,867	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.216603	0	513,692	0		58.00
60.00	06000	LABORATORY	0.256596	0	3,173,841	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.432242	0	91,167	0		65.00
66.00	06600	PHYSICAL THERAPY	0.311301	0	1,223,240	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.379283	0	171,496	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443558	0	195,172	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.596325	0	86,423	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287683	0	918,968	8,878		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		75.00
75.01	03951	SLEEP LAB	0.297237	0	144,560	0		75.01
75.02	03952	WOUND CENTER	0.625148	0	87,819	0		75.02
76.00	03953	CARDIAC REHAB	1.044258	0	106,884	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.494961	0	754,290	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.409447	0	84,175	0		92.00
200.00		Subtotal (see instructions)		0	13,361,044	8,878		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,361,044	8,878		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	484,602	0		50.00
53.00	05300	ANESTHESIOLOGY	0	4,689	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	344,753	0		54.00
54.01	05401	ULTRASOUND	0	77,056	0		54.01
56.00	05600	RADIOISOTOPE	0	251,858	0		56.00
57.00	05700	CT SCAN	0	178,927	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	111,267	0		58.00
60.00	06000	LABORATORY	0	814,395	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	39,406	0		65.00
66.00	06600	PHYSICAL THERAPY	0	380,796	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	65,046	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	86,570	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	51,536	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	264,371	2,554		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		75.00
75.01	03951	SLEEP LAB	0	42,969	0		75.01
75.02	03952	WOUND CENTER	0	54,900	0		75.02
76.00	03953	CARDIAC REHAB	0	111,614	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	373,344	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	118,640	0		92.00
200.00		Subtotal (see instructions)	0	3,856,739	2,554		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,856,739	2,554		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.483264	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.210396	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.410420	0	0	0		54.00
54.01	05401	ULTRASOUND	0.109510	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0.378875	0	0	0		56.00
57.00	05700	CT SCAN	0.069463	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.216603	0	0	0		58.00
60.00	06000	LABORATORY	0.256596	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.432242	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.311301	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.379283	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443558	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.596325	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287683	0	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		75.00
75.01	03951	SLEEP LAB	0.297237	0	0	0		75.01
75.02	03952	WOUND CENTER	0.625148	0	0	0		75.02
76.00	03953	CARDIAC REHAB	1.044258	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.494961	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.409447	0	0	0		92.00
200.00		Subtotal (see instructions)		0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		75.00
75.01	03951	SLEEP LAB	0	0	0		75.01
75.02	03952	WOUND CENTER	0	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,015	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)	2,675	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	352	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)	385	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,922	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)	352	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)	385	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	3,110,677	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	118	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)	589	25.00
26.00	Total swing-bed cost (see instructions)	611,592	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,499,085	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,537,450	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,537,450	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.625474	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)	574.75	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)	2,499,085	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)	828.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,593,107	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)	1,593,107	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,151,490	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,744,597	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	291,766	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	319,119	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	610,885	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)	340	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	828.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	281,819	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		961,000		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483264	261,665	126,453	50.00
53.00	05300	ANESTHESIOLOGY	0.210396	10,720	2,255	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.410420	86,720	35,592	54.00
54.01	05401	ULTRASOUND	0.109510	227,863	24,953	54.01
56.00	05600	RADIOISOTOPE	0.378875	92,042	34,872	56.00
57.00	05700	CT SCAN	0.069463	339,172	23,560	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.216603	52,753	11,426	58.00
60.00	06000	LABORATORY	0.256596	783,961	201,161	60.00
65.00	06500	RESPIRATORY THERAPY	0.432242	104,962	45,369	65.00
66.00	06600	PHYSICAL THERAPY	0.311301	151,898	47,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379283	29,524	11,198	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443558	104,998	46,573	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.596325	329,636	196,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287683	1,195,673	343,975	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.297237	0	0	75.01
75.02	03952	WOUND CENTER	0.625148	0	0	75.02
76.00	03953	CARDIAC REHAB	1.044258	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.494961	500	247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.409447	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,772,087	1,151,490	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)		3,772,087		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3

Component CCN: 14Z349 | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		103,220		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483264	4,998	2,415	50.00
53.00	05300	ANESTHESIOLOGY	0.210396	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.410420	11,123	4,565	54.00
54.01	05401	ULTRASOUND	0.109510	11,673	1,278	54.01
56.00	05600	RADIOISOTOPE	0.378875	0	0	56.00
57.00	05700	CT SCAN	0.069463	34,863	2,422	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.216603	5,639	1,221	58.00
60.00	06000	LABORATORY	0.256596	84,102	21,580	60.00
65.00	06500	RESPIRATORY THERAPY	0.432242	26,615	11,504	65.00
66.00	06600	PHYSICAL THERAPY	0.311301	231,168	71,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.379283	754	286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443558	13,501	5,988	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.596325	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.287683	309,653	89,082	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.297237	0	0	75.01
75.02	03952	WOUND CENTER	0.625148	3,313	2,071	75.02
76.00	03953	CARDIAC REHAB	1.044258	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.494961	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.409447	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		737,402	214,375	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)		737,402		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,859,293	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,859,293	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)	3,897,886	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,240	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,016,809	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)	1,841,837	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)	1,841,837	30.00
31.00	Primary payer payments	250	31.00
32.00	Subtotal (line 30 minus line 31)	1,841,587	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)	355,240	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	355,240	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	309,367	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,196,827	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,196,827	40.00
41.00	Interim payments	2,134,156	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)	62,671	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 10/30/2012 4:20 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,212,233		2,240,966	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	06/22/2012	72,217		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	06/22/2012	106,810	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)		72,217		-106,810	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)		2,284,450		2,134,156	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		149,978		62,671	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,434,428		2,196,827	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 10/30/2012 4:20 pm

Component CCN: 14Z349 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		766,653		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	06/22/2012	54,180		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)		-54,180		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)		712,473		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		103,618		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		816,091		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: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet E-1 Part II Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Hospital	Cost

		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	840	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,922	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	5	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,675	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	49,181,309	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	593,358	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	433,521	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	402,783	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)	402,783	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141349 Component CCN: 14Z349	Period: From 07/01/2011 To 06/30/2012	Worksheet E-2 Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	616,994	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)	216,519	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	737	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)	833,513	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	833,513	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)	833,513	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,422	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)	816,091	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	816,091	0	19.00
20.00	Interim payments	712,473	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)	103,618	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,744,597	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,744,597	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,772,043	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,772,043	19.00
20.00	Deductibles (exclude professional component)	406,994	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,365,049	22.00
23.00	Coinsurance	7,641	23.00
24.00	Subtotal (line 22 minus line 23)	2,357,408	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	77,020	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	77,020	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	63,247	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,434,428	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,434,428	30.00
31.00	Interim payments	2,284,450	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	149,978	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 10/30/2012 4:20 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	7,182,381	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	4,208,549	0	0	0	4.00
5.00	Other receivable	840,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	556,659	0	0	0	7.00
8.00	Prepaid expenses	605,826	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,393,415	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	179,834	0	0	0	12.00
13.00	Land improvements	778,902	0	0	0	13.00
14.00	Accumulated depreciation	-587,414	0	0	0	14.00
15.00	Buildings	15,861,997	0	0	0	15.00
16.00	Accumulated depreciation	-9,303,890	0	0	0	16.00
17.00	Leasehold improvements	23,103	0	0	0	17.00
18.00	Accumulated depreciation	-10,735	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,622,399	0	0	0	23.00
24.00	Accumulated depreciation	-8,075,408	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	433,521	0	0	0	27.00
28.00	Accumulated depreciation	-71,381	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)	9,850,928	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,162,501	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	104,919	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,267,420	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,511,763	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	821,104	0	0	0	37.00
38.00	Salaries, wages, and fees payable	448,852	0	0	0	38.00
39.00	Payroll taxes payable	819,371	0	0	0	39.00
40.00	Notes and loans payable (short term)	370,226	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	486,039	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,945,592	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,357,681	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	4,357,681	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,303,273	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,208,490				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)	18,208,490	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,511,763	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 10/30/2012 4:20 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		17,361,885		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		846,605				2.00
3.00	Total (sum of line 1 and line 2)		18,208,490		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,208,490		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)		18,208,490		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 10/30/2012 4:20 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts | Date/Time Prepared: 10/30/2012 4:20 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,340,500		1,340,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	103,220		103,220	5.00
6.00	Swing bed - NF	840		840	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,444,560		1,444,560	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,444,560		1,444,560	17.00
18.00	Ancillary services	6,171,979	32,372,439	38,544,418	18.00
19.00	Outpatient services	93,325	3,975,876	4,069,201	19.00
20.00	RURAL HEALTH CLINIC	0	4,677,821	4,677,821	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,140,161	1,140,161	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	0	749,550	749,550	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,709,864	42,915,847	50,625,711	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,595,502		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	NON-OPERATING RENTAL EXPENSE	405			37.00
38.00	INTEREST EXPENSE	163,920			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)		164,325		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,431,177		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-3 | Date/Time Prepared: 10/30/2012 4:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	50,625,711	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,857,326	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,768,385	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,431,177	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-662,792	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	691,654	6.00
7.00	Income from investments	79,329	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	39,847	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	51,354	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	35,330	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	20,595	22.00
23.00	Governmental appropriations	241,572	23.00
24.00	MISCELLANEOUS INCOME	138,266	24.00
24.01	EHR INCENTIVE PAYMENTS	375,370	24.01
25.00	Total other income (sum of lines 6-24)	1,673,317	25.00
26.00	Total (line 5 plus line 25)	1,010,525	26.00
27.00	INTEREST EXPENSE	163,920	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	163,920	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	846,605	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H

HHA CCN: 147694 | Date/Time Prepared: 10/30/2012 4:20 pm

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		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	129,768	0	0	0	86,375	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	259,417	0	0	0	0	6.00
7.00	Physical Therapy	56,792	0	0	13,200	0	7.00
8.00	Occupational Therapy	0	0	0	25,226	0	8.00
9.00	Speech Pathology	0	0	0	9,780	0	9.00
10.00	Medical Social Services	0	0	0	480	0	10.00
11.00	Home Health Aide	4,372	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	450,349	0	0	48,686	86,375	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H

HHA CCN: 147694 | Date/Time Prepared: 10/30/2012 4:20 pm

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		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	216,143	-5,455	210,688	0	210,688	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	259,417	0	259,417	0	259,417	6.00
7.00	Physical Therapy	69,992	0	69,992	0	69,992	7.00
8.00	Occupational Therapy	25,226	0	25,226	0	25,226	8.00
9.00	Speech Pathology	9,780	0	9,780	0	9,780	9.00
10.00	Medical Social Services	480	0	480	0	480	10.00
11.00	Home Health Aide	4,372	0	4,372	0	4,372	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	585,410	-5,455	579,955	0	579,955	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: 141349 HHA CCN: 147694

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

Worksheet H-1 Part I Date/Time Prepared: 10/30/2012 4:20 pm

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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	210,688	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	259,417	0	0	0	0	6.00
7.00	Physical Therapy	69,992	0	0	0	0	7.00
8.00	Occupational Therapy	25,226	0	0	0	0	8.00
9.00	Speech Pathology	9,780	0	0	0	0	9.00
10.00	Medical Social Services	480	0	0	0	0	10.00
11.00	Home Health Aide	4,372	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	579,955	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-1 Part I | Date/Time Prepared: 10/30/2012 4:20 pm

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	210,688	210,688			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	259,417	148,013	407,430		6.00
7.00	Physical Therapy	69,992	39,934	109,926		7.00
8.00	Occupational Therapy	25,226	14,393	39,619		8.00
9.00	Speech Pathology	9,780	5,580	15,360		9.00
10.00	Medical Social Services	480	274	754		10.00
11.00	Home Health Aide	4,372	2,494	6,866		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	369,267		579,955		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-1 Part II Date/Time Prepared: 10/30/2012 4:20 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	-210,688	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-210,688	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: 141349 HHA CCN: 147694

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

Worksheet H-1 Part II Date/Time Prepared: 10/30/2012 4:20 pm

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	369,267		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	259,417		6.00
7.00	Physical Therapy	69,992		7.00
8.00	Occupational Therapy	25,226		8.00
9.00	Speech Pathology	9,780		9.00
10.00	Medical Social Services	480		10.00
11.00	Home Health Aide	4,372		11.00
12.00	Supplies (see instructions)	0		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	369,267		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	210,688		25.00
26.00	Unit Cost Multiplier	0.570557		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	0	15,225	0	14,060	29,467	1.00
2.00	Skilled Nursing Care	407,430	0	0	0	61,041	2.00
3.00	Physical Therapy	109,926	0	0	0	13,363	3.00
4.00	Occupational Therapy	39,619	0	0	0	0	4.00
5.00	Speech Pathology	15,360	0	0	0	0	5.00
6.00	Medical Social Services	754	0	0	0	0	6.00
7.00	Home Health Aide	6,866	0	0	0	1,029	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	579,955	15,225	0	14,060	104,900	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: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I | Date/Time Prepared: 10/30/2012 4:20 pm

HHA CCN: 147694 | Home Health Agency I | PPS

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4A	5.00	6.00	7.00	8.00	
1.00	Administrative and General	58,752	14,819	6,019	0	0	1.00
2.00	Skilled Nursing Care	468,471	118,165	0	0	0	2.00
3.00	Physical Therapy	123,289	31,098	0	0	0	3.00
4.00	Occupational Therapy	39,619	9,993	0	0	0	4.00
5.00	Speech Pathology	15,360	3,874	0	0	0	5.00
6.00	Medical Social Services	754	190	0	0	0	6.00
7.00	Home Health Aide	7,895	1,991	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	714,140	180,130	6,019	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.	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: 141349 HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		9.00	10.00	11.00	13.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	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: 141349 HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-2 Part I Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	0	79,590	0	1.00
2.00	Skilled Nursing Care	0	0	0	586,636	0	2.00
3.00	Physical Therapy	0	0	0	154,387	0	3.00
4.00	Occupational Therapy	0	0	0	49,612	0	4.00
5.00	Speech Pathology	0	0	0	19,234	0	5.00
6.00	Medical Social Services	0	0	0	944	0	6.00
7.00	Home Health Aide	0	0	0	9,886	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	900,289	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: 141349 HHA CCN: 147694

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

Worksheet H-2 Part I Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		26.00	27.00	28.00		
1.00	Administrative and General	79,590				1.00
2.00	Skilled Nursing Care	586,636	56,891	643,527		2.00
3.00	Physical Therapy	154,387	14,972	169,359		3.00
4.00	Occupational Therapy	49,612	4,811	54,423		4.00
5.00	Speech Pathology	19,234	1,865	21,099		5.00
6.00	Medical Social Services	944	92	1,036		6.00
7.00	Home Health Aide	9,886	959	10,845		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	900,289	79,590	900,289		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.		0.096978			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: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 10/30/2012 4:20 pm

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	1,434	0	13,683	125,233	0	1.00
2.00	Skilled Nursing Care	0	0	0	259,417	0	2.00
3.00	Physical Therapy	0	0	0	56,792	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	4,372	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,434	0	13,683	445,814		20.00
21.00	Total cost to be allocated	15,225	0	14,060	104,900		21.00
22.00	Unit cost multiplier	10.617155	0.000000	1.027552	0.235300		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 10/30/2012 4:20 pm

Home Health Agency I

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	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	58,752	1,434	0	0	0	1.00
2.00	Skilled Nursing Care	468,471	0	0	0	0	2.00
3.00	Physical Therapy	123,289	0	0	0	0	3.00
4.00	Occupational Therapy	39,619	0	0	0	0	4.00
5.00	Speech Pathology	15,360	0	0	0	0	5.00
6.00	Medical Social Services	754	0	0	0	0	6.00
7.00	Home Health Aide	7,895	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	714,140	1,434	0	0	0	20.00
21.00	Total cost to be allocated	180,130	6,019	0	0	0	21.00
22.00	Unit cost multiplier	0.252233	4.197350	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 10/30/2012 4:20 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		17.00	19.00		
1.00	Administrative and General	0	0		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0		20.00
21.00	Total cost to be allocated	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 10/30/2012 4:20 pm

HHA CCN: 147694 | 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	643,527		643,527	3,252	1.00
2.00	Physical Therapy	3.00	169,359	0	169,359	2,033	2.00
3.00	Occupational Therapy	4.00	54,423	0	54,423	315	3.00
4.00	Speech Pathology	5.00	21,099	0	21,099	106	4.00
5.00	Medical Social Services	6.00	1,036		1,036	6	5.00
6.00	Home Health Aide	7.00	10,845		10,845	56	6.00
7.00	Total (sum of lines 1-6)		900,289	0	900,289	5,768	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		99914	1,400	729		8.00
8.01	Skilled Nursing Care		41180	135	44		8.01
9.00	Physical Therapy		99914	996	351		9.00
9.01	Physical Therapy		41180	99	36		9.01
10.00	Occupational Therapy		99914	160	15		10.00
10.01	Occupational Therapy		41180	25	0		10.01
11.00	Speech Pathology		99914	39	0		11.00
11.01	Speech Pathology		41180	32	0		11.01
12.00	Medical Social Services		99914	1	4		12.00
12.01	Medical Social Services		41180	0	1		12.01
13.00	Home Health Aide		99914	28	12		13.00
13.01	Home Health Aide		41180	13	2		13.01
14.00	Total (sum of lines 8-13)			2,928	1,194		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	21,160	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	0.311301	0	0	1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	2.00
3.00	Speech Pathology	68.00	0.000000	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.443558	0	0	4.00
5.00	Cost of Drugs	73.00	0.287683	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II | Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	197.89	1,535	773			1.00
2.00	Physical Therapy	83.30	1,095	387			2.00
3.00	Occupational Therapy	172.77	185	15			3.00
4.00	Speech Pathology	199.05	71	0			4.00
5.00	Medical Social Services	172.67	1	5			5.00
6.00	Home Health Aide	193.66	41	14			6.00
7.00	Total (sum of lines 1-6)		2,928	1,194			7.00

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

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000					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	col. 2, line 3.00		2.00
3.00	Speech Pathology	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00		4.00
5.00	Cost of Drugs	col. 2, line 16.00		5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-3 Parts I-II Date/Time Prepared: 10/30/2012 4:20 pm

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	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	303,761	152,969		456,730		1.00
2.00	Physical Therapy	91,214	32,237		123,451		2.00
3.00	Occupational Therapy	31,962	2,592		34,554		3.00
4.00	Speech Pathology	14,133	0		14,133		4.00
5.00	Medical Social Services	173	863		1,036		5.00
6.00	Home Health Aide	7,940	2,711		10,651		6.00
7.00	Total (sum of lines 1-6)	449,183	191,372		640,555		7.00

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

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

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/30/2012 4:20 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	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	432,354	212,552	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	11,553	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	3,327	2,577	13.00
14.00	Total PPS Reimbursement - PEP Episodes	6,452	3,816	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	637	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	454,323	218,945	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	454,323	218,945	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	454,323	218,945	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)	454,323	218,945	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	454,323	218,945	31.00
32.00	Interim payments (see instructions)	454,323	218,945	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: 141349 HHA CCN: 147694 | Period: From 07/01/2011 To 06/30/2012 | Worksheet H-5 | Date/Time Prepared: 10/30/2012 4:20 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		454,323		218,945	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)		454,323		218,945	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)		454,323		218,945	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 10/30/2012 4:20 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	1,398,807	0	1,398,807	0	1,398,807	1.00
2.00	Physician Assistant	220,037	0	220,037	0	220,037	2.00
3.00	Nurse Practitioner	354,870	0	354,870	0	354,870	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	699,025	0	699,025	0	699,025	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)	2,672,739	0	2,672,739	0	2,672,739	10.00
11.00	Physician Services Under Agreement	0	176,400	176,400	0	176,400	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	176,400	176,400	0	176,400	14.00
15.00	Medical Supplies	0	35,320	35,320	0	35,320	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	141,291	141,291	0	141,291	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	176,611	176,611	0	176,611	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,672,739	353,011	3,025,750	0	3,025,750	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	232,706	232,706	0	232,706	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	10,056	10,056	0	10,056	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	242,762	242,762	0	242,762	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	145,073	145,073	0	145,073	29.00
30.00	Administrative Costs	368,918	643,762	1,012,680	-521,106	491,574	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	368,918	788,835	1,157,753	-521,106	636,647	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,041,657	1,384,608	4,426,265	-521,106	3,905,159	32.00

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

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1

Component CCN: 143464 | Date/Time Prepared: 10/30/2012 4:20 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	-4,997	1,393,810		1.00
2.00	Physician Assistant	0	220,037		2.00
3.00	Nurse Practitioner	0	354,870		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	699,025		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)	-4,997	2,667,742		10.00
11.00	Physician Services Under Agreement	0	176,400		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	176,400		14.00
15.00	Medical Supplies	0	35,320		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	141,291		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	176,611		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-4,997	3,020,753		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	232,706		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	10,056		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	242,762		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	145,073		29.00
30.00	Administrative Costs	0	491,574		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	636,647		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,997	3,900,162		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141349 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-2

Component CCN: 143464 | Date/Time Prepared: 10/30/2012 4:20 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	5.41	20,322	4,200	22,722		1.00
2.00	Physician Assistant	1.81	12,935	2,100	3,801		2.00
3.00	Nurse Practitioner	3.31	5,533	2,100	6,951		3.00
4.00	Subtotal (sum of lines 1-3)	10.53	38,790		33,474	38,790	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)	10.53	38,790			38,790	8.00
9.00	Physician Services Under Agreements		1,574			1,574	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)					3,020,753	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					242,762	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,263,515	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.925613	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					636,647	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,398,760	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,035,407	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					3,035,407	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,809,612	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					5,830,365	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3 Date/Time Prepared: 10/30/2012 4:20 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)		5,830,365	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		85,514	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,744,851	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		38,790	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		1,574	5.00
6.00	Total adjusted visits (line 4 plus line 5)		40,364	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		142.33	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)	142.33	142.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	5,264	5,264	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	749,225	749,225	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) *	749,225	749,225	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,081,497	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,590	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,300	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,073,085	16.04
16.05	Total program cost (see instructions)		1,104,385	16.05
17.00	Primary payer amounts		480	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		125,794	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		186,623	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,103,905	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		33,412	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,137,317	22.00
23.00	Reimbursable bad debts (see instructions)		13,295	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		13,295	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)		1,150,612	26.00
27.00	Interim payments		969,291	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)		181,321	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: 141349 Component CCN: 143464	Period: From 07/01/2011 To 06/30/2012	Worksheet M-4 Date/Time Prepared: 10/30/2012 4:20 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,667,742	2,667,742	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000891	0.002444	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,377	6,520	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	11,926	21,831	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,303	28,351	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	3,020,753	3,020,753	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	3,035,407	3,035,407	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004735	0.009385	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	14,373	28,487	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	28,676	56,838	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	606	1,663	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	47.32	34.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	121	810	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,726	27,686	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)		85,514	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)		33,412	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 10/30/2012 4:20 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		969,291	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)		969,291	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		181,321	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,150,612	7.00

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