Morrison Community Hospital

Medicare Cost Report

FYE: June 30, 2012

McGladrey

Assurance ▪ Tax ▪ Consulting

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: 141329	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/7/2012 8:46 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/7/2012 Time: 8:46 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON 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.

Encryption Information

ECR: Date: 11/7/2012 Time: 8:46 pm
m1mql9H:aVrgFjOl0gq5c6rMed3nh0
6OpZO0Jvjy4i6AgZ1epUHrAipqZWBE
zTmA05S32g0.XOFJ

PI: Date: 11/7/2012 Time: 8:46 pm
ZVLIvQLHxAn70Ry9LzYH7duPhX24D0
BjoRI0OOkyZAh16Phmz1zD1BVKPdGK
D66gLkSJCi0IoAjq

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	11,951	-36,025	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	141,170	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		23,203		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	153,121	-12,822	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/7/2012 8:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	MORRISON SNF	145274	99914		08/13/1974	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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
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

C:\Client\Client Folders\Morrison Community Hospital\COST REPORT\Morrison 2012.mcrx

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		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

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

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		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

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

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00

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		V	XIX	
		1.00	2.00	
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		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.	Y		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	N	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
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.	1,000,000	3,000,000	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

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		1.00	2.00	
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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/7/2012 8:46 pm

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	09/28/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/7/2012 8:46 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.				Y	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				Y	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.				Y	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.	CAMI	MEGLI	41.00
42.00	Enter the employer/company name of the cost report preparer.	MORRISON COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-772-5533	CMEGLI@MCHSTAFF.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 11/7/2012 8:46 pm

		Part B					
		Y/N	Date				
		3.00	4.00				
	PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N					16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/28/2012				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N					18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N					19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N					20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					21.00
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CONTROLLER				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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2012 8:46 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	6,264.00		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	6,264.00		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	6,264.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	38	13,908			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	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		63				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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2012 8:46 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	161	9	261		1.00
2.00	HMO		2	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	2,404	0	2,629		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	189		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,565	9	3,079		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	2,565	9	3,079		14.00
15.00	CAH visits	0	1,733	1,144	5,470		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	6,331	10,045		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	0	1,855	5,528	17,635		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		19	85		28.00
29.00	Ambulance Trips		232				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2012 8:46 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	53	1.00
2.00	HMO					2	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	103.09	0.00	0	53	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	21.21	0.00			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	0.00	10.35	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	134.65	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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/7/2012 8:46 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)	13	95		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)	13	95		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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-7 | Date/Time Prepared: 11/7/2012 8:46 pm

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

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-7 | Date/Time Prepared: 11/7/2012 8:46 pm

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

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914		201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	690,484	40.21	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,717,232			207.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-8 | Date/Time Prepared: 11/7/2012 8:46 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	300 NORTH JACKSON STREET	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	MORRISON IL 61270	2.00
		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic	08:00	20:00	08:00	20:00	11.00

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

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

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

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

Provider CCN: 141329
Component CCN: 143981

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

Worksheet S-8

Date/Time Prepared: 11/7/2012 8:46 pm

		Rural Health Clinic (RHC) I	Cost
		County	
		4.00	
2.00	City, State, Zip Code, County	WHITESIDE	2.00

		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/7/2012 8:46 pm
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/7/2012 8:46 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-10 | Date/Time Prepared: 11/7/2012 8:46 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)	0.783800	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,693,083	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	64,855	5.00
6.00	Medicaid charges	3,404,403	6.00
7.00	Medicaid cost (line 1 times line 6)	2,668,371	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)	910,433	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)	910,433	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	59,254	3,543	62,797	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	46,443	2,777	49,220	21.00
22.00	Partial payment by patients approved for charity care	5,482	692	6,174	22.00
23.00	Cost of charity care (line 21 minus line 22)	40,961	2,085	43,046	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)	629,974	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	85,286	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	544,688	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	426,926	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	469,972	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,380,405	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		567,095	567,095	-156,677	410,418	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		30,807	30,807	334,981	365,788	2.00
4.00	00400	EMPLOYEE BENEFITS	0	1,134,954	1,134,954	0	1,134,954	4.00
5.01	00510	PURCHASING	28,426	4,636	33,062	0	33,062	5.01
5.02	00511	PERSONNEL	100,401	14,015	114,416	0	114,416	5.02
5.03	00512	HOSPITAL BILLING	248,787	111,960	360,747	0	360,747	5.03
5.04	00513	NURSING HOME BILLING	155	68	223	0	223	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	281,507	797,069	1,078,576	177,799	1,256,375	5.05
7.00	00700	OPERATION OF PLANT	136,582	327,745	464,327	0	464,327	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,264	58,264	0	58,264	8.00
9.00	00900	HOUSEKEEPING	164,694	38,843	203,537	0	203,537	9.00
10.00	01000	DIETARY	191,577	116,384	307,961	0	307,961	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	108,008	5,466	113,474	0	113,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,412	14,537	39,949	0	39,949	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,547	30,460	190,007	0	190,007	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	2,941	574	3,515	0	3,515	16.01
17.00	01700	SOCIAL SERVICE	58,416	3,472	61,888	0	61,888	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,096,959	197,331	1,294,290	-7,769	1,286,521	30.00
44.00	04400	SKILLED NURSING FACILITY	653,721	104,459	758,180	-869	757,311	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	93,166	153,326	246,492	-7,805	238,687	50.00
53.00	05300	ANESTHESIOLOGY	0	51,138	51,138	0	51,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,865	72,896	271,761	168	271,929	54.00
60.00	06000	LABORATORY	279,362	283,261	562,623	1,017	563,640	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,810	28,810	-7,775	21,035	65.00
66.00	06600	PHYSICAL THERAPY	274,436	8,133	282,569	0	282,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,793	2,286	122,079	0	122,079	67.00
68.00	06800	SPEECH PATHOLOGY	2,638	2,396	5,034	0	5,034	68.00
69.00	06900	ELECTROCARDIOLOGY	2,856	7,122	9,978	0	9,978	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,085	18,085	15,815	33,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,403	8,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,241	324,374	450,615	0	450,615	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	604,879	841,653	1,446,532	-119,062	1,327,470	88.00
91.00	09100	EMERGENCY	348,761	654,785	1,003,546	-93,123	910,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	100,935	34,688	135,623	-2,787	132,836	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		142,316	142,316	-142,316	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,409,065	6,183,408	11,592,473	0	11,592,473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	5,409,065	6,183,408	11,592,473	0	11,592,473	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-11,305	399,113		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-2,817	362,971		2.00
4.00	00400	EMPLOYEE BENEFITS	-3,015	1,131,939		4.00
5.01	00510	PURCHASING	0	33,062		5.01
5.02	00511	PERSONNEL	0	114,416		5.02
5.03	00512	HOSPITAL BILLING	-7,968	352,779		5.03
5.04	00513	NURSING HOME BILLING	0	223		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-65,828	1,190,547		5.05
7.00	00700	OPERATION OF PLANT	0	464,327		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,264		8.00
9.00	00900	HOUSEKEEPING	0	203,537		9.00
10.00	01000	DIETARY	-24,323	283,638		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	113,474		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,949		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,918	187,089		16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	3,515		16.01
17.00	01700	SOCIAL SERVICE	0	61,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,367	1,285,154		30.00
44.00	04400	SKILLED NURSING FACILITY	0	757,311		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-48,936	189,751		50.00
53.00	05300	ANESTHESIOLOGY	-3,638	47,500		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,296	266,633		54.00
60.00	06000	LABORATORY	-31,548	532,092		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-40	20,995		65.00
66.00	06600	PHYSICAL THERAPY	-500	282,069		66.00
67.00	06700	OCCUPATIONAL THERAPY	-97	121,982		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,034		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,174	4,804		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,598	32,302		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,403		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,726	447,889		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-77,099	1,250,371		88.00
91.00	09100	EMERGENCY	-82,414	828,009		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-880	131,956		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-379,487	11,212,986		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-379,487	11,212,986		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/7/2012 8:46 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	135,048		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	1,825		2.00
3.00	AMBULANCE SERVICES	95.00	0	4,258		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	168		4.00
5.00	LABORATORY	60.00	0	1,017		5.00
	TOTALS		0	142,316		
	B - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,431		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,825		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	175,974		3.00
	TOTALS		0	219,230		
	C - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	328,156		1.00
	TOTALS		0	328,156		
	D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,403		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	8,403		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,413		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	16,413		
500.00	Grand Total: Increases		0	714,518		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/7/2012 8:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	142,316	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	142,316			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	93,123	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	119,062	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	7,045	0		3.00
	TOTALS		0	219,230			
	C - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	328,156	9		1.00
	TOTALS		0	328,156			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	7,805	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	598	0		2.00
	TOTALS		0	8,403			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	7,769	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	869	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	7,775	0		3.00
	TOTALS		0	16,413			
500.00	Grand Total: Decreases		0	714,518			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/7/2012 8:46 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	21,657	0	0	0	0	1.00
2.00	Land Improvements	507,947	52,569	0	52,569	0	2.00
3.00	Buildings and Fixtures	7,641,390	43,604	0	43,604	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	328,274	0	0	0	0	5.00
6.00	Movable Equipment	3,625,724	139,711	0	139,711	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,124,992	235,884	0	235,884	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,124,992	235,884	0	235,884	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	567,095	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,885	0	8,922	0	0	2.00
3.00	Total (sum of lines 1-2)	588,980	0	8,922	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	8,476,069	0	8,476,069	0.692404	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,765,434	0	3,765,434	0.307596	0	2.00
3.00	Total (sum of lines 1-2)	12,241,503	0	12,241,503	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/7/2012 8:46 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0				1.00
2.00	Land Improvements	560,516	0				2.00
3.00	Buildings and Fixtures	7,684,994	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	328,274	0				5.00
6.00	Movable Equipment	3,765,435	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	12,360,876	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	12,360,876	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	567,095				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	30,807				2.00
3.00	Total (sum of lines 1-2)	0	597,902				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	238,939	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	347,224	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	586,163	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	123,743	36,431	0	0	399,113	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,922	6,825	0	0	362,971	2.00
3.00	Total (sum of lines 1-2)	132,665	43,256	0	0	762,084	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-11,305	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,699	OTHER ADMINISTRATIVE AND GENERAL	5.05	7.00
8.00	Television and radio service (chapter 21)	A	-2,817	NEW CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-162,864			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	-22,669	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	-1,598	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-2,918	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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		0		0.00	32.00
33.00	LAB OTHER REVENUE	B	-15,227	LABORATORY	60.00	33.00
34.00	INVESTMENT INCOME-OTHER	B	-153	OTHER ADMINISTRATIVE AND GENERAL	5.05	34.00
35.00	INVESTMENT INCOME-OTHER	B	-356	AMBULANCE SERVICES	95.00	35.00
36.00	INVESTMENT INCOME-OTHER	B	-14	RADIOLOGY-DIAGNOSTIC	54.00	36.00
37.00	INVESTMENT INCOME-OTHER	B	-85	LABORATORY	60.00	37.00
38.00	OTHER REV -A&G	B	-1,106	OTHER ADMINISTRATIVE AND GENERAL	5.05	38.00
39.00	OTHER REV - DIETARY	B	-1,654	DIETARY	10.00	39.00
40.00	OTHER REV - AMBULANCE	B	-524	AMBULANCE SERVICES	95.00	40.00
41.00	OTHER REV -PHYSICAL THERAPY	B	-99	PHYSICAL THERAPY	66.00	41.00
42.00	NONALLOWABLE DUES	A	-3,344	OTHER ADMINISTRATIVE AND GENERAL	5.05	42.00
43.00	PATIENT TELEPHONE - SALARIES	A	-6,400	OTHER ADMINISTRATIVE AND GENERAL	5.05	43.00
44.00	PATIENT TELEPHONE - BENEFITS	A	-1,343	EMPLOYEE BENEFITS	4.00	44.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
45.00	PHYSICIAN BILLING SALARIES	A	-7,968	HOSPITAL BILLING	5.03	45.00
45.01	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-1,672	EMPLOYEE BENEFITS	4.00	45.01
45.02	ADVERTISING	A	-50,051	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.02
45.03	OTHER REV- EDUCATION	A	-75	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.03
45.04	SELF INSURANCE EXPENSE	A	-22,836	OPERATING ROOM	50.00	45.04
45.05	SELF INSURANCE EXPENSE	A	-3,638	ANESTHESIOLOGY	53.00	45.05
45.06	SELF INSURANCE EXPENSE	A	-5,282	RADIOLOGY-DIAGNOSTIC	54.00	45.06
45.07	SELF INSURANCE EXPENSE	A	-16,236	LABORATORY	60.00	45.07
45.08	SELF INSURANCE EXPENSE	A	-40	RESPIRATORY THERAPY	65.00	45.08
45.09	SELF INSURANCE EXPENSE	A	-401	PHYSICAL THERAPY	66.00	45.09
45.10	SELF INSURANCE EXPENSE	A	-97	OCCUPATIONAL THERAPY	67.00	45.10
45.11	SELF INSURANCE EXPENSE	A	-139	ELECTROCARDIOLOGY	69.00	45.11
45.12	SELF INSURANCE EXPENSE	A	-2,726	DRUGS CHARGED TO PATIENTS	73.00	45.12
45.13	SELF INSURANCE EXPENSE	A	-4,160	EMERGENCY	91.00	45.13
45.14	SELF INSURANCE EXPENSE	A	-1,367	ADULTS & PEDIATRICS	30.00	45.14
45.15	SELF INSURANCE EXPENSE	A	-23,624	RURAL HEALTH CLINIC	88.00	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-379,487			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	Wkst. A-7 Ref.				
		5.00				
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11				1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0				2.00
3.00	Investment income - other (chapter 2)	0				3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0				4.00
5.00	Refunds and rebates of expenses (chapter 8)	0				5.00
6.00	Rental of provider space by suppliers (chapter 8)	0				6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0				7.00
8.00	Television and radio service (chapter 21)	9				8.00
9.00	Parking lot (chapter 21)	0				9.00
10.00	Provider-based physician adjustment	0				10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0				11.00
12.00	Related organization transactions (chapter 10)	0				12.00
13.00	Laundry and linen service	0				13.00
14.00	Cafeteria-employees and guests	0				14.00
15.00	Rental of quarters to employee and others	0				15.00
16.00	Sale of medical and surgical supplies to other than patients	0				16.00
17.00	Sale of drugs to other than patients	0				17.00
18.00	Sale of medical records and abstracts	0				18.00
19.00	Nursing school (tuition, fees, books, etc.)	0				19.00
20.00	Vending machines	0				20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0				21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0				22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)					23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)					24.00
25.00	Utilization review - physicians' compensation (chapter 21)					25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0				26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0				27.00
28.00	Non-physician Anesthetist					28.00
29.00	Physicians' assistant	0				29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)					30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)					31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0				32.00
33.00	LAB OTHER REVENUE	0				33.00
34.00	INVESTMENT INCOME-OTHER	0				34.00
35.00	INVESTMENT INCOME-OTHER	0				35.00
36.00	INVESTMENT INCOME-OTHER	0				36.00
37.00	INVESTMENT INCOME-OTHER	0				37.00
38.00	OTHER REV -A&G	0				38.00
39.00	OTHER REV - DIETARY	0				39.00
40.00	OTHER REV - AMBULANCE	0				40.00
41.00	OTHER REV -PHYSICAL THERAPY	0				41.00
42.00	NONALLOWABLE DUES	0				42.00
43.00	PATIENT TELEPHONE - SALARIES	0				43.00
44.00	PATIENT TELEPHONE - BENEFITS	0				44.00
45.00	PHYSICIAN BILLING SALARIES	0				45.00
45.01	PHYSICIAN BILLING EMPLOYEE BENEFITS	0				45.01
45.02	ADVERTISING	0				45.02
45.03	OTHER REV- EDUCATION	0				45.03
45.04	SELF INSURANCE EXPENSE	0				45.04
45.05	SELF INSURANCE EXPENSE	0				45.05
45.06	SELF INSURANCE EXPENSE	0				45.06
45.07	SELF INSURANCE EXPENSE	0				45.07
45.08	SELF INSURANCE EXPENSE	0				45.08
45.09	SELF INSURANCE EXPENSE	0				45.09
45.10	SELF INSURANCE EXPENSE	0				45.10
45.11	SELF INSURANCE EXPENSE	0				45.11
45.12	SELF INSURANCE EXPENSE	0				45.12
45.13	SELF INSURANCE EXPENSE	0				45.13

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	Wkst. A-7 Ref.		
		5.00		
45.14	SELF INSURANCE EXPENSE	0		45.14
45.15	SELF INSURANCE EXPENSE	0		45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/7/2012 8:46 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	502,634	78,254	1.00
2.00		91.00	EMERGENCY	6,300	0	2.00
3.00		50.00	OPERATING ROOM	26,100	26,100	3.00
4.00		69.00	ELECTROCARDIOLOGY	5,035	5,035	4.00
5.00		88.00	RURAL HEALTH CLINIC	53,475	53,475	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				593,544	162,864	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/7/2012 8:46 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		424,380	0	0	0	0	1.00
2.00		6,300	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		430,680		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/7/2012 8:46 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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/7/2012 8:46 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	78,254		1.00
2.00		0	0		2.00
3.00		0	26,100		3.00
4.00		0	5,035		4.00
5.00		0	53,475		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	162,864		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 11/7/2012 8:46 pm

Physical 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)					9	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	29.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	90.73	72.59	54.44	36.29	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)	36.30	36.30	27.22			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)					2,105	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)					2,105	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)					2,105	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)					72.59	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					3,267	22.00
23.00	Total salary equivalency (see instructions)					3,267	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)					327	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)					327	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)					50	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					377	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)					377	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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 11/7/2012 8:46 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)	72.59	54.44	36.29	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)	3,267		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	377		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)	3,644		63.00
64.00	Total cost of outside supplier services (from your records)	1,980		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	327		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	50		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	377		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	50		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	50		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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 11/7/2012 8:46 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					20	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	25.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	82.63	66.10	49.58	33.05	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	24.79			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)					1,686	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)					1,686	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)					1,686	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)					66.12	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,910	22.00
23.00	Total salary equivalency (see instructions)					10,910	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)					661	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)					661	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)					111	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					772	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)					772	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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Par | Date/Time Prepared: 11/7/2012 8:46 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	49.58	33.05	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)	10,910		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	772		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)	11,682		63.00
64.00	Total cost of outside supplier services (from your records)	1,890		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	661		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	111		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	772		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	111		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	111		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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	PURCHASING	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	399,113	399,113				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	362,971		362,971			2.00
4.00	00400	EMPLOYEE BENEFITS	1,131,939	0	0	1,131,939		4.00
5.01	00510	PURCHASING	33,062	11,626	0	5,949	50,637	5.01
5.02	00511	PERSONNEL	114,416	3,697	0	21,011	552	5.02
5.03	00512	HOSPITAL BILLING	352,779	6,383	4,093	52,063	1,448	5.03
5.04	00513	NURSING HOME BILLING	223	646	0	32	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,190,547	19,259	28,586	58,910	2,781	5.05
7.00	00700	OPERATION OF PLANT	464,327	71,870	5,957	28,582	1,609	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,264	9,152	0	0	92	8.00
9.00	00900	HOUSEKEEPING	203,537	3,820	0	34,465	1,057	9.00
10.00	01000	DIETARY	283,638	10,588	498	40,091	1,563	10.00
11.00	01100	CAFETERIA	0	4,074	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	113,474	5,407	0	22,603	575	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,949	3,573	0	5,318	8,641	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,089	8,410	1,184	33,388	919	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	3,515	687	0	615	0	16.01
17.00	01700	SOCIAL SERVICE	61,888	1,051	0	12,225	23	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,285,154	64,312	46,332	229,557	3,517	30.00
44.00	04400	SKILLED NURSING FACILITY	757,311	60,602	1,901	136,802	2,873	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,751	14,395	94,790	19,497	2,161	50.00
53.00	05300	ANESTHESIOLOGY	47,500	0	0	0	391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,633	9,571	66,789	41,616	1,494	54.00
60.00	06000	LABORATORY	532,092	9,661	32,299	58,461	3,678	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,995	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	282,069	9,956	1,506	57,430	1,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,982	3,401	0	25,069	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,034	0	0	552	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,804	0	831	598	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,302	0	0	0	1,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,403	0	0	0	759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	447,889	3,326	7,935	26,418	713	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,250,371	35,674	10,344	126,581	5,172	88.00
91.00	09100	EMERGENCY	828,009	8,596	11,040	72,984	4,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	131,956	19,376	48,886	21,122	2,850	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,212,986	399,113	362,971	1,131,939	50,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	11,212,986	399,113	362,971	1,131,939	50,637	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL	139,676					5.02
5.03	00512	HOSPITAL BILLING	6,581	423,347				5.03
5.04	00513	NURSING HOME BILLING	4	0	905			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	7,447	0	0	1,307,530	1,307,530	5.05
7.00	00700	OPERATION OF PLANT	3,613	0	0	575,958	76,027	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	67,508	8,911	8.00
9.00	00900	HOUSEKEEPING	4,357	0	0	247,236	32,635	9.00
10.00	01000	DIETARY	5,068	0	0	341,446	45,071	10.00
11.00	01100	CAFETERIA	0	0	0	4,074	538	11.00
13.00	01300	NURSING ADMINISTRATION	2,857	0	0	144,916	19,129	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	672	0	0	58,153	7,676	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,220	0	0	235,210	31,048	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	78	0	0	4,895	646	16.01
17.00	01700	SOCIAL SERVICE	1,545	0	0	76,732	10,129	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,014	54,935	0	1,712,821	226,094	30.00
44.00	04400	SKILLED NURSING FACILITY	17,293	0	905	977,687	129,056	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,465	28,415	0	351,474	46,395	50.00
53.00	05300	ANESTHESIOLOGY	0	4,758	0	52,649	6,950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,261	48,573	0	439,937	58,072	54.00
60.00	06000	LABORATORY	7,390	55,564	0	699,145	92,288	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,021	0	25,016	3,302	65.00
66.00	06600	PHYSICAL THERAPY	7,260	40,980	0	400,442	52,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,169	17,437	0	171,058	22,580	67.00
68.00	06800	SPEECH PATHOLOGY	70	543	0	6,199	818	68.00
69.00	06900	ELECTROCARDIOLOGY	76	2,722	0	9,031	1,192	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,028	0	41,307	5,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,261	0	10,423	1,376	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,339	54,075	0	543,695	71,768	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,001	70,386	0	1,514,529	199,919	88.00
91.00	09100	EMERGENCY	9,226	18,218	0	952,624	125,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,670	14,431	0	241,291	31,851	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	139,676	423,347	905	11,212,986	1,307,530	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	139,676	423,347	905	11,212,986	1,307,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	651,985					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,891	97,310				8.00
9.00	00900	HOUSEKEEPING	8,720	0	288,591			9.00
10.00	01000	DIETARY	24,169	0	1,553	412,239		10.00
11.00	01100	CAFETERIA	9,300	0	0	80,331	94,243	11.00
13.00	01300	NURSING ADMINISTRATION	12,343	0	3,370	0	1,642	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,155	0	4,896	0	20	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,197	0	5,244	0	4,692	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	1,568	0	941	0	98	16.01
17.00	01700	SOCIAL SERVICE	2,400	0	1,440	0	987	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	146,799	19,673	86,605	77,969	24,943	30.00
44.00	04400	SKILLED NURSING FACILITY	138,330	65,197	79,948	253,198	20,731	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,857	1,657	13,020	0	2,864	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,847	3,328	11,608	0	3,978	54.00
60.00	06000	LABORATORY	22,051	0	13,237	0	5,718	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	22,726	1,027	13,642	0	3,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,763	0	4,660	0	1,153	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	20	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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,591	0	3,822	0	1,759	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	81,430	1,578	32,828	0	10,449	88.00
91.00	09100	EMERGENCY	19,620	4,325	11,777	0	8,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	44,228	525	0	0	2,483	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	651,985	97,310	288,591	411,498	94,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	741	0	194.02
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)	651,985	97,310	288,591	412,239	94,243	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBRA	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	181,400					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,900				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,245	297,636			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	8,148		16.01
17.00	01700	SOCIAL SERVICE	3,108	56	0	0	94,852	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,899	8,586	38,623	0	43,276	30.00
44.00	04400	SKILLED NURSING FACILITY	0	7,015	0	8,148	51,576	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,065	5,275	19,977	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	954	3,345	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,648	34,150	0	0	54.00
60.00	06000	LABORATORY	0	8,979	39,065	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,827	0	0	65.00
66.00	06600	PHYSICAL THERAPY	12,026	3,030	28,811	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,632	0	12,259	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	70	0	381	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,914	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,826	4,941	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,852	887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,554	1,740	38,018	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,043	12,625	49,483	0	0	88.00
91.00	09100	EMERGENCY	28,156	11,111	12,809	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,847	6,958	10,146	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	181,400	78,900	297,636	8,148	94,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	181,400	78,900	297,636	8,148	94,852	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PURCHASING					5.01
5.02	00511	PERSONNEL					5.02
5.03	00512	HOSPITAL BILLING					5.03
5.04	00513	NURSING HOME BILLING					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,464,288	-11,587	2,452,701		30.00
44.00	04400	SKILLED NURSING FACILITY	1,730,886	0	1,730,886		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	482,584	0	482,584		50.00
53.00	05300	ANESTHESIOLOGY	63,898	0	63,898		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,568	0	576,568		54.00
60.00	06000	LABORATORY	880,483	0	880,483		60.00
64.00	06400	INTRAVENOUS THERAPY	0	27,675	27,675		64.00
65.00	06500	RESPIRATORY THERAPY	31,145	0	31,145		65.00
66.00	06600	PHYSICAL THERAPY	538,365	0	538,365		66.00
67.00	06700	OCCUPATIONAL THERAPY	223,105	0	223,105		67.00
68.00	06800	SPEECH PATHOLOGY	7,488	0	7,488		68.00
69.00	06900	ELECTROCARDIOLOGY	12,137	0	12,137		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,527	0	56,527		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,538	0	14,538		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	673,947	-16,088	657,859		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,935,884	0	1,935,884		88.00
91.00	09100	EMERGENCY	1,175,073	0	1,175,073		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	345,329	0	345,329		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,212,245	0	11,212,245		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	741	0	741		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	11,212,986	0	11,212,986		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01	00510	PURCHASING	0	11,626	0	11,626	0	5.01
5.02	00511	PERSONNEL	0	3,697	0	3,697	0	5.02
5.03	00512	HOSPITAL BILLING	565	6,383	4,093	11,041	0	5.03
5.04	00513	NURSING HOME BILLING	0	646	0	646	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	19,259	28,586	47,845	0	5.05
7.00	00700	OPERATION OF PLANT	341	71,870	5,957	78,168	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,152	0	9,152	0	8.00
9.00	00900	HOUSEKEEPING	0	3,820	0	3,820	0	9.00
10.00	01000	DIETARY	960	10,588	498	12,046	0	10.00
11.00	01100	CAFETERIA	0	4,074	0	4,074	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,407	0	5,407	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,573	0	3,573	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,715	8,410	1,184	11,309	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	32	687	0	719	0	16.01
17.00	01700	SOCIAL SERVICE	0	1,051	0	1,051	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,590	64,312	46,332	144,234	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	60,602	1,901	62,503	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,313	14,395	94,790	158,498	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,332	9,571	66,789	86,692	0	54.00
60.00	06000	LABORATORY	0	9,661	32,299	41,960	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,035	0	0	21,035	0	65.00
66.00	06600	PHYSICAL THERAPY	57	9,956	1,506	11,519	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,401	0	3,401	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	831	831	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,013	3,326	7,935	15,274	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,420	35,674	10,344	48,438	0	88.00
91.00	09100	EMERGENCY	7,424	8,596	11,040	27,060	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	19,376	48,886	68,262	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,797	399,113	362,971	893,881	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	131,797	399,113	362,971	893,881	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	PURCHASING	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING	11,626					5.01
5.02	00511	PERSONNEL	127	3,824				5.02
5.03	00512	HOSPITAL BILLING	332	180	11,553			5.03
5.04	00513	NURSING HOME BILLING	0	0	0	646		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	639	204	0	0	48,688	5.05
7.00	00700	OPERATION OF PLANT	369	99	0	0	2,831	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21	0	0	0	332	8.00
9.00	00900	HOUSEKEEPING	243	119	0	0	1,215	9.00
10.00	01000	DIETARY	359	139	0	0	1,678	10.00
11.00	01100	CAFETERIA	0	0	0	0	20	11.00
13.00	01300	NURSING ADMINISTRATION	132	78	0	0	712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,985	18	0	0	286	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	211	116	0	0	1,156	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	2	0	0	24	16.01
17.00	01700	SOCIAL SERVICE	5	42	0	0	377	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	807	796	1,499	0	8,424	30.00
44.00	04400	SKILLED NURSING FACILITY	660	473	0	646	4,805	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496	67	775	0	1,727	50.00
53.00	05300	ANESTHESIOLOGY	90	0	130	0	259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	343	144	1,325	0	2,162	54.00
60.00	06000	LABORATORY	844	202	1,516	0	3,436	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	110	0	123	65.00
66.00	06600	PHYSICAL THERAPY	285	199	1,118	0	1,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	87	476	0	841	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	15	0	30	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2	74	0	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454	0	192	0	203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	174	0	34	0	51	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164	91	1,475	0	2,672	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,187	438	1,923	0	7,444	88.00
91.00	09100	EMERGENCY	1,045	253	497	0	4,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	654	73	394	0	1,186	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,626	3,824	11,553	646	48,688	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	11,626	3,824	11,553	646	48,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	81,467					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,610	12,115				8.00
9.00	00900	HOUSEKEEPING	1,090	0	6,487			9.00
10.00	01000	DIETARY	3,020	0	35	17,277		10.00
11.00	01100	CAFETERIA	1,162	0	0	3,367	8,623	11.00
13.00	01300	NURSING ADMINISTRATION	1,542	0	76	0	150	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,019	0	110	0	2	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,399	0	118	0	429	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	196	0	21	0	9	16.01
17.00	01700	SOCIAL SERVICE	300	0	32	0	90	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,342	2,449	1,945	3,268	2,282	30.00
44.00	04400	SKILLED NURSING FACILITY	17,285	8,119	1,797	10,611	1,897	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,106	206	293	0	262	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,730	414	261	0	364	54.00
60.00	06000	LABORATORY	2,755	0	298	0	523	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,840	128	307	0	348	66.00
67.00	06700	OCCUPATIONAL THERAPY	970	0	105	0	106	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2	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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	948	0	86	0	161	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,175	196	738	0	956	88.00
91.00	09100	EMERGENCY	2,452	538	265	0	815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,526	65	0	0	227	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,467	12,115	6,487	17,246	8,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	31	0	194.02
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)	81,467	12,115	6,487	17,277	8,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBRA	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	8,097					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,993				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	199	15,937			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	971		16.01
17.00	01700	SOCIAL SERVICE	139	5	0	0	2,041	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,521	761	2,068	0	931	30.00
44.00	04400	SKILLED NURSING FACILITY	0	622	0	971	1,110	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	405	468	1,069	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	85	179	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	323	1,828	0	0	54.00
60.00	06000	LABORATORY	0	796	2,091	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	151	0	0	65.00
66.00	06600	PHYSICAL THERAPY	537	269	1,542	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	162	0	656	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	20	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	102	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	428	265	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	164	47	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248	154	2,035	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,475	1,117	2,655	0	0	88.00
91.00	09100	EMERGENCY	1,257	985	686	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	350	617	543	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,097	6,993	15,937	971	2,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	8,097	6,993	15,937	971	2,041	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PURCHASING					5.01
5.02	00511	PERSONNEL					5.02
5.03	00512	HOSPITAL BILLING					5.03
5.04	00513	NURSING HOME BILLING					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	191,327	0	191,327		30.00
44.00	04400	SKILLED NURSING FACILITY	111,499	0	111,499		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	168,372	0	168,372		50.00
53.00	05300	ANESTHESIOLOGY	743	0	743		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,586	0	96,586		54.00
60.00	06000	LABORATORY	54,421	0	54,421		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	21,419	0	21,419		65.00
66.00	06600	PHYSICAL THERAPY	21,060	0	21,060		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,804	0	6,804		67.00
68.00	06800	SPEECH PATHOLOGY	72	0	72		68.00
69.00	06900	ELECTROCARDIOLOGY	1,053	0	1,053		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,542	0	1,542		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	470	0	470		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,308	0	23,308		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	76,742	0	76,742		88.00
91.00	09100	EMERGENCY	40,535	0	40,535		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	77,897	0	77,897		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	893,850	0	893,850		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	31	0	31		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	893,881	0	893,881		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	PURCHASING (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	58,087					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		328,156				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	5,409,065			4.00
5.01	00510	PURCHASING	1,692	0	28,426	2,203		5.01
5.02	00511	PERSONNEL	538	0	100,401	24	5,280,238	5.02
5.03	00512	HOSPITAL BILLING	929	3,700	248,787	63	248,787	5.03
5.04	00513	NURSING HOME BILLING	94	0	155	0	155	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,803	25,844	281,507	121	281,507	5.05
7.00	00700	OPERATION OF PLANT	10,460	5,386	136,582	70	136,582	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	4	0	8.00
9.00	00900	HOUSEKEEPING	556	0	164,694	46	164,694	9.00
10.00	01000	DIETARY	1,541	450	191,577	68	191,577	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	787	0	108,008	25	108,008	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	25,412	376	25,412	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,224	1,070	159,547	40	159,547	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	100	0	2,941	0	2,941	16.01
17.00	01700	SOCIAL SERVICE	153	0	58,416	1	58,416	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,360	41,888	1,096,959	153	1,096,959	30.00
44.00	04400	SKILLED NURSING FACILITY	8,820	1,719	653,721	125	653,721	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,095	85,698	93,166	94	93,166	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	60,383	198,865	65	198,865	54.00
60.00	06000	LABORATORY	1,406	29,201	279,362	160	279,362	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,449	1,362	274,436	54	274,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	119,793	0	119,793	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,638	0	2,638	68.00
69.00	06900	ELECTROCARDIOLOGY	0	751	2,856	0	2,856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	86	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	33	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484	7,174	126,241	31	126,241	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,192	9,352	604,879	225	604,879	88.00
91.00	09100	EMERGENCY	1,251	9,981	348,761	198	348,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	44,197	100,935	124	100,935	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,087	328,156	5,409,065	2,203	5,280,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	399,113	362,971	1,131,939	50,637	139,676	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.870952	1.106093	0.209267	22.985474	0.026453	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	11,626	3,824	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	5.277349	0.000724	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	HOSPITAL BILLING (NON-NURSING HOME CHARGES)	NURSING HOME BILLING (NURSING HOME CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING	12,676,313					5.03
5.04	00513	NURSING HOME BILLING	0	1,717,232				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-1,307,530	9,905,456		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	575,958	41,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	67,508	1,332	8.00
9.00	00900	HOUSEKEEPING	0	0	0	247,236	556	9.00
10.00	01000	DIETARY	0	0	0	341,446	1,541	10.00
11.00	01100	CAFETERIA	0	0	0	4,074	593	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	144,916	787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	58,153	520	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	235,210	1,224	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	4,895	100	16.01
17.00	01700	SOCIAL SERVICE	0	0	0	76,732	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,644,912	0	0	1,712,821	9,360	30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,717,232	0	977,687	8,820	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	850,810	0	0	351,474	2,095	50.00
53.00	05300	ANESTHESIOLOGY	142,469	0	0	52,649	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,454,416	0	0	439,937	1,393	54.00
60.00	06000	LABORATORY	1,663,757	0	0	699,145	1,406	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	120,387	0	0	25,016	0	65.00
66.00	06600	PHYSICAL THERAPY	1,227,054	0	0	400,442	1,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	522,100	0	0	171,058	495	67.00
68.00	06800	SPEECH PATHOLOGY	16,246	0	0	6,199	0	68.00
69.00	06900	ELECTROCARDIOLOGY	81,512	0	0	9,031	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,440	0	0	41,307	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	37,760	0	0	10,423	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,619,163	0	0	543,695	484	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,107,682	0	0	1,514,529	5,192	88.00
91.00	09100	EMERGENCY	545,508	0	0	952,624	1,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	432,097	0	0	241,291	2,820	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,676,313	1,717,232	-1,307,530	9,905,456	41,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	423,347	905		1,307,530	651,985	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.033397	0.000527		0.132001	15.683650	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,553	646		48,688	81,467	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000911	0.000376		0.004915	1.959707	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,964					8.00
9.00	00900	HOUSEKEEPING	0	30,654				9.00
10.00	01000	DIETARY	0	165	47,289			10.00
11.00	01100	CAFETERIA	0	0	9,215	9,642		11.00
13.00	01300	NURSING ADMINISTRATION	0	358	0	168	122,061	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	520	0	2	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	557	0	480	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	100	0	10	0	16.01
17.00	01700	SOCIAL SERVICE	0	153	0	101	2,091	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,249	9,199	8,944	2,552	53,090	30.00
44.00	04400	SKILLED NURSING FACILITY	17,396	8,492	29,045	2,121	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	442	1,383	0	293	6,100	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	888	1,233	0	407	0	54.00
60.00	06000	LABORATORY	0	1,406	0	585	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	274	1,449	0	389	8,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	495	0	118	2,444	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2	47	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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	406	0	180	3,737	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	421	3,487	0	1,069	22,234	88.00
91.00	09100	EMERGENCY	1,154	1,251	0	911	18,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	140	0	0	254	5,280	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,964	30,654	47,204	9,642	122,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	85	0	0	194.02
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)	97,310	288,591	412,239	94,243	181,400	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.747882	9.414465	8.717440	9.774217	1.486142	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,115	6,487	17,277	8,623	8,097	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.466608	0.211620	0.365349	0.894317	0.066336	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/7/2012 8:46 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (PURCHASE ORDERS)	MEDICAL RECORDS & LIBRARY (NON-NURSING HOME CHARGES)	NURSING HOME MEDICAL RECORDS & LIBRA (NURSING HOME CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			14.00	16.00	16.01	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,406					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40	12,676,313				16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	1,717,232			16.01
17.00	01700	SOCIAL SERVICE	1	0	0	320		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	153	1,644,912	0	146		30.00
44.00	04400	SKILLED NURSING FACILITY	125	0	1,717,232	174		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94	850,810	0	0		50.00
53.00	05300	ANESTHESIOLOGY	17	142,469	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65	1,454,416	0	0		54.00
60.00	06000	LABORATORY	160	1,663,757	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	120,387	0	0		65.00
66.00	06600	PHYSICAL THERAPY	54	1,227,054	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	522,100	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	16,246	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,512	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86	210,440	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	33	37,760	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31	1,619,163	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	225	2,107,682	0	0		88.00
91.00	09100	EMERGENCY	198	545,508	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	124	432,097	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,406	12,676,313	1,717,232	320		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02
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)	78,900	297,636	8,148	94,852		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.116643	0.023480	0.004745	296.412500		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,993	15,937	971	2,041		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.973684	0.001257	0.000565	6.378125		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-2 | Date/Time Prepared: 11/7/2012 8:46 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		IV THERAPY	1	64.00	27,675	5.00
6.00		IV THERAPY	1	30.00	-11,587	6.00
7.00		IV THERAPY	1	73.00	-16,088	7.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,452,701		2,452,701	0	2,452,701	30.00
44.00	04400	SKILLED NURSING FACILITY	1,730,886		1,730,886	0	1,730,886	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	482,584		482,584	0	482,584	50.00
53.00	05300	ANESTHESIOLOGY	63,898		63,898	0	63,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,568		576,568	0	576,568	54.00
60.00	06000	LABORATORY	880,483		880,483	0	880,483	60.00
64.00	06400	INTRAVENOUS THERAPY	27,675		27,675	0	27,675	64.00
65.00	06500	RESPIRATORY THERAPY	31,145	0	31,145	0	31,145	65.00
66.00	06600	PHYSICAL THERAPY	538,365	0	538,365	0	538,365	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,105	0	223,105	0	223,105	67.00
68.00	06800	SPEECH PATHOLOGY	7,488	0	7,488	0	7,488	68.00
69.00	06900	ELECTROCARDIOLOGY	12,137		12,137	0	12,137	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,527		56,527	0	56,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,538		14,538	0	14,538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,859		657,859	0	657,859	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,935,884		1,935,884	0	1,935,884	88.00
91.00	09100	EMERGENCY	1,175,073		1,175,073	0	1,175,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,413		69,413		69,413	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	345,329		345,329	0	345,329	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,281,658	0	11,281,658	0	11,281,658	200.00
201.00		Less Observation Beds	69,413		69,413		69,413	201.00
202.00		Total (see instructions)	11,212,245	0	11,212,245	0	11,212,245	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 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	1,460,472		1,460,472			30.00
44.00	04400	SKILLED NURSING FACILITY	1,717,232		1,717,232			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	850,810	850,810	0.567205	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	142,469	142,469	0.448505	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,387	1,391,029	1,454,416	0.396426	0.000000	54.00
60.00	06000	LABORATORY	163,296	1,500,461	1,663,757	0.529214	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	194,881	163,357	358,238	0.077253	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	95,271	25,116	120,387	0.258707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	668,542	558,512	1,227,054	0.438746	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,252	85,848	522,100	0.427322	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,895	9,351	16,246	0.460913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,726	73,786	81,512	0.148898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,883	109,558	210,441	0.268612	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,760	37,760	0.385011	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	736,930	523,995	1,260,925	0.521727	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	48,415	2,059,267	2,107,682			88.00
91.00	09100	EMERGENCY	1,107	544,401	545,508	2.154089	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	184,441	184,441	0.376343	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	432,097	432,097	0.799193	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,701,289	8,692,258	14,393,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,701,289	8,692,258	14,393,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 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
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,452,701		2,452,701	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	1,730,886		1,730,886	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	482,584		482,584	0	0	50.00
53.00	05300	ANESTHESIOLOGY	63,898		63,898	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,568		576,568	0	0	54.00
60.00	06000	LABORATORY	880,483		880,483	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	27,675		27,675	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,145	0	31,145	0	0	65.00
66.00	06600	PHYSICAL THERAPY	538,365	0	538,365	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,105	0	223,105	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,488	0	7,488	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,137		12,137	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,527		56,527	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,538		14,538	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,859		657,859	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,935,884		1,935,884	0	0	88.00
91.00	09100	EMERGENCY	1,175,073		1,175,073	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	69,413		69,413		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	345,329		345,329	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,281,658	0	11,281,658	0	0	200.00
201.00		Less Observation Beds	69,413		69,413		0	201.00
202.00		Total (see instructions)	11,212,245	0	11,212,245	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,460,472		1,460,472			30.00
44.00	04400	SKILLED NURSING FACILITY	1,717,232		1,717,232			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	850,810	850,810	0.567205	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	142,469	142,469	0.448505	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,387	1,391,029	1,454,416	0.396426	0.000000	54.00
60.00	06000	LABORATORY	163,296	1,500,461	1,663,757	0.529214	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	194,881	163,357	358,238	0.077253	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	95,271	25,116	120,387	0.258707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	668,542	558,512	1,227,054	0.438746	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,252	85,848	522,100	0.427322	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,895	9,351	16,246	0.460913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,726	73,786	81,512	0.148898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,883	109,558	210,441	0.268612	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,760	37,760	0.385011	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	736,930	523,995	1,260,925	0.521727	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	48,415	2,059,267	2,107,682	0.918490	0.000000	88.00
91.00	09100	EMERGENCY	1,107	544,401	545,508	2.154089	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	184,441	184,441	0.376343	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	432,097	432,097	0.799193	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,701,289	8,692,258	14,393,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,701,289	8,692,258	14,393,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/7/2012 8:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/7/2012 8:46 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	168,372	850,810	0.197896	0	0	50.00
53.00	05300	ANESTHESIOLOGY	743	142,469	0.005215	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,586	1,454,416	0.066409	14,633	972	54.00
60.00	06000	LABORATORY	54,421	1,663,757	0.032710	38,071	1,245	60.00
64.00	06400	INTRAVENOUS THERAPY	0	358,238	0.000000	10,990	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,419	120,387	0.177918	12,726	2,264	65.00
66.00	06600	PHYSICAL THERAPY	21,060	1,227,054	0.017163	1,490	26	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,804	522,100	0.013032	1,674	22	67.00
68.00	06800	SPEECH PATHOLOGY	72	16,246	0.004432	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,053	81,512	0.012918	1,272	16	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,542	210,441	0.007327	19,431	142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	470	37,760	0.012447	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,308	1,260,925	0.018485	79,509	1,470	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	76,742	2,107,682	0.036411	0	0	88.00
91.00	09100	EMERGENCY	40,535	545,508	0.074307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	184,441	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	513,127	10,783,746		179,796	6,157	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/7/2012 8:46 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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/7/2012 8:46 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	850,810	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	142,469	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,454,416	0.000000	0.000000	14,633	54.00
60.00	06000	LABORATORY	0	1,663,757	0.000000	0.000000	38,071	60.00
64.00	06400	INTRAVENOUS THERAPY	0	358,238	0.000000	0.000000	10,990	64.00
65.00	06500	RESPIRATORY THERAPY	0	120,387	0.000000	0.000000	12,726	65.00
66.00	06600	PHYSICAL THERAPY	0	1,227,054	0.000000	0.000000	1,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	522,100	0.000000	0.000000	1,674	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,246	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,512	0.000000	0.000000	1,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	210,441	0.000000	0.000000	19,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,760	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,260,925	0.000000	0.000000	79,509	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,107,682	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	545,508	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	184,441	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,783,746			179,796	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/7/2012 8:46 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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/7/2012 8:46 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
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/7/2012 8:46 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	0.567205	0	334,076	0		50.00
53.00	05300	ANESTHESIOLOGY	0.448505	0	50,913	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.396426	0	328,229	0		54.00
60.00	06000	LABORATORY	0.529214	0	459,143	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0.077253	0	109,684	0		64.00
65.00	06500	RESPIRATORY THERAPY	0.258707	0	16,846	0		65.00
66.00	06600	PHYSICAL THERAPY	0.438746	0	252,972	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.427322	0	29,678	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.460913	0	210	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.148898	0	29,423	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268612	0	89,073	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.385011	0	26,370	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.521727	0	66,622	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	2.154089	0	155,340	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.376343	0	79,020	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.799193		0			95.00
200.00		Subtotal (see instructions)		0	2,027,599	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	2,027,599	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	189,490	0		50.00
53.00	05300	ANESTHESIOLOGY	0	22,835	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	130,119	0		54.00
60.00	06000	LABORATORY	0	242,985	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	8,473	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	4,358	0		65.00
66.00	06600	PHYSICAL THERAPY	0	110,990	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,682	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	97	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,381	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,926	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,153	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,758	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	334,616	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	29,739	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	0	1,159,602	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	1,159,602	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/7/2012 8:46 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	0.567205	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.448505	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.396426	0	0	0		54.00
60.00	06000	LABORATORY	0.529214	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0.077253	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0.258707	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.438746	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.427322	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.460913	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.148898	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268612	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.385011	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.521727	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	2.154089	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.376343	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.799193		0			95.00
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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Component CCN: 145274 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	850,810	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	142,469	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,454,416	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	1,663,757	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	358,238	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	120,387	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,227,054	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	522,100	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,246	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,512	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	210,441	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,760	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,260,925	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,107,682	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	545,508	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	184,441	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,783,746			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Component CCN: 145274 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/7/2012 8:46 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)	3,164	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	346	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)	261	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,175	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)	1,454	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	117	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)	72	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	161	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)	1,086	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)	1,318	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	122.21	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	125.88	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,452,701	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)	14,299	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)	9,063	25.00
26.00	Total swing-bed cost (see instructions)	2,170,151	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	282,550	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	447,182	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	447,182	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.631846	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,713.34	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)	282,550	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)	816.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	131,469	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)	131,469	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/7/2012 8:46 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)	78,349	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	209,818	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)	886,806	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,076,252	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,963,058	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)	85	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	816.62	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	69,413	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/7/2012 8:46 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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/7/2012 8:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,045	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,045	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)	10,045	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,730,886	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,730,886	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,717,232	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,717,232	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.007951	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)	170.95	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,730,886	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,730,886	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	172.31	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1

Component CCN: 145274 | Date/Time Prepared: 11/7/2012 8:46 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/7/2012 8:46 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		156,605		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.567205	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.448505	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.396426	14,633	5,801	54.00
60.00	06000	LABORATORY	0.529214	38,071	20,148	60.00
64.00	06400	INTRAVENOUS THERAPY	0.077253	10,990	849	64.00
65.00	06500	RESPIRATORY THERAPY	0.258707	12,726	3,292	65.00
66.00	06600	PHYSICAL THERAPY	0.438746	1,490	654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.427322	1,674	715	67.00
68.00	06800	SPEECH PATHOLOGY	0.460913	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148898	1,272	189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268612	19,431	5,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.385011	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.521727	79,509	41,482	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.154089	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.376343	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		179,796	78,349	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)		179,796		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/7/2012 8:46 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		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.567205	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.448505	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.396426	27,096	10,742	54.00
60.00	06000	LABORATORY	0.529214	96,334	50,981	60.00
64.00	06400	INTRAVENOUS THERAPY	0.077253	13,410	1,036	64.00
65.00	06500	RESPIRATORY THERAPY	0.258707	75,209	19,457	65.00
66.00	06600	PHYSICAL THERAPY	0.438746	588,759	258,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.427322	383,994	164,089	67.00
68.00	06800	SPEECH PATHOLOGY	0.460913	4,933	2,274	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148898	5,918	881	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.268612	68,696	18,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.385011	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.521727	657,111	342,833	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.154089	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.376343	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,921,460	869,062	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,921,460		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/7/2012 8:46 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,159,602	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)	1,159,602	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)	1,171,198	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)	12,210	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	311,854	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)	847,134	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)	847,134	30.00
31.00	Primary payer payments	168	31.00
32.00	Subtotal (line 30 minus line 31)	846,966	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)	53,120	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	53,120	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51,081	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	900,086	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)	900,086	40.00
41.00	Interim payments	936,111	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)	-36,025	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: 141329	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/7/2012 8:46 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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I Date/Time Prepared: 11/7/2012 8:46 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		185,672		964,613	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	02/24/2012	13,768		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	06/01/2012	31,531	02/24/2012	10,460	3.50
3.51			0	06/01/2012	18,042	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)		-17,763		-28,502	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)		167,909		936,111	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		11,951		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		36,025	6.02
7.00	Total Medicare program liability (see instructions)		179,860		900,086	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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 11/7/2012 8:46 pm

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		2,892,192		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	02/24/2012	90,025		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	06/01/2012	341,054		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)		-251,029		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)		2,641,163		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		141,170		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,782,333		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 - SWING BEDS

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-2 | Date/Time Prepared: 11/7/2012 8:46 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)	1,982,689	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)	877,753	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	2,404	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)	2,860,442	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,860,442	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)	2,860,442	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	95,490	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)	2,764,952	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	17,381	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	14,692	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,782,333	0	19.00
20.00	Interim payments	2,641,163	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)	141,170	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: 141329	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/7/2012 8:46 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	209,818	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)	209,818	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	211,916	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)	211,916	19.00
20.00	Deductibles (exclude professional component)	41,136	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	170,780	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	170,780	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,080	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,080	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,080	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	179,860	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)	179,860	30.00
31.00	Interim payments	167,909	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)	11,951	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 11/7/2012 8:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 11/7/2012 8:46 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	984,436	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	2,336,078	0	0	0	4.00
5.00	Other receivable	894,364	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	144,648	0	0	0	7.00
8.00	Prepaid expenses	122,119	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)	4,481,645	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	560,517	0	0	0	13.00
14.00	Accumulated depreciation	-261,034	0	0	0	14.00
15.00	Buildings	7,684,994	0	0	0	15.00
16.00	Accumulated depreciation	-4,349,850	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	328,274	0	0	0	19.00
20.00	Accumulated depreciation	-324,917	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	3,765,434	0	0	0	23.00
24.00	Accumulated depreciation	-2,746,231	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,678,844	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	671,981	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	671,981	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,832,470	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	246,744	0	0	0	37.00
38.00	Salaries, wages, and fees payable	355,057	0	0	0	38.00
39.00	Payroll taxes payable	85,191	0	0	0	39.00
40.00	Notes and loans payable (short term)	192,421	0	0	0	40.00
41.00	Deferred income	452,000	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	329,089	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,660,502	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,335,096	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,335,096	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,995,598	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,836,872				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)	4,836,872	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,832,470	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/7/2012 8:46 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		4,623,353		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		213,519				2.00
3.00	Total (sum of line 1 and line 2)		4,836,872		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)		4,836,872		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)		4,836,872		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/7/2012 8:46 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: 141329 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts | Date/Time Prepared: 11/7/2012 8:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	447,182		447,182	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,257,066		1,257,066	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,717,232		1,717,232	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,421,480		3,421,480	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,421,480		3,421,480	17.00
18.00	Ancillary services	2,449,645	5,700,501	8,150,146	18.00
19.00	Outpatient services	1,596	797,955	799,551	19.00
20.00	RURAL HEALTH CLINIC	0	2,199,150	2,199,150	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	432,097	432,097	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,872,721	9,129,703	15,002,424	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,592,473		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		11,592,473		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141329	Period: From 07/01/2011 To 06/30/2012	Worksheet G-3 Date/Time Prepared: 11/7/2012 8:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	15,002,424	1.00
2.00	Less contractual allowances and discounts on patients' accounts	3,584,026	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,418,398	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,592,473	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-174,075	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	17,831	6.00
7.00	Income from investments	11,913	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	22,669	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	1,598	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	3,052	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	67,963	24.00
24.01	COUNTY TAX REVENUE	862,087	24.01
24.02	STATE TAX REVENUE	80,304	24.02
25.00	Total other income (sum of lines 6-24)	1,067,417	25.00
26.00	Total (line 5 plus line 25)	893,342	26.00
27.00	BAD DEBTS	629,974	27.00
27.01	CHARITY CARE	49,849	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	679,823	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	213,519	29.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 11/7/2012 8:46 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	604,879	0	604,879	0	604,879	9.00
10.00	Subtotal (sum of lines 1-9)	604,879	0	604,879	0	604,879	10.00
11.00	Physician Services Under Agreement	0	545,716	545,716	0	545,716	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	65,305	65,305	0	65,305	13.00
14.00	Subtotal (sum of lines 11-13)	0	611,021	611,021	0	611,021	14.00
15.00	Medical Supplies	0	74,336	74,336	0	74,336	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	119,062	119,062	-119,062	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	193,398	193,398	-119,062	74,336	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	604,879	804,419	1,409,298	-119,062	1,290,236	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,722	4,722	0	4,722	29.00
30.00	Administrative Costs	0	32,512	32,512	0	32,512	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	37,234	37,234	0	37,234	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	604,879	841,653	1,446,532	-119,062	1,327,470	32.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 11/7/2012 8:46 pm

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-53,475	551,404		9.00
10.00	Subtotal (sum of lines 1-9)	-53,475	551,404		10.00
11.00	Physician Services Under Agreement	0	545,716		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	65,305		13.00
14.00	Subtotal (sum of lines 11-13)	0	611,021		14.00
15.00	Medical Supplies	0	74,336		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	74,336		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-53,475	1,236,761		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,722		29.00
30.00	Administrative Costs	-23,624	8,888		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-23,624	13,610		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-77,099	1,250,371		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-2 | Date/Time Prepared: 11/7/2012 8:46 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	2.36	13,485	4,200	9,912		1.00
2.00	Physician Assistant	0.47	4,150	2,100	987		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	2.83	17,635		10,899	17,635	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.83	17,635			17,635	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,236,761	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,236,761	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					13,610	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					685,513	15.00
16.00	Total overhead (sum of lines 14 and 15)					699,123	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					699,123	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					699,123	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,935,884	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3 Date/Time Prepared: 11/7/2012 8:46 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,935,884	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,126	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,931,758	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		17,635	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,635	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		109.54	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)	109.54	109.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,855	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	203,197	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	203,197	16.00
16.01	Total program charges (see instructions)(from contractor's records)		214,248	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		554	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		525	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.)		141,066	16.04
16.05	Total program cost (see instructions)		141,591	16.05
17.00	Primary payer amounts		275	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,340	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		141,316	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		447	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		141,763	22.00
23.00	Reimbursable bad debts (see instructions)		5,705	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		5,061	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)		147,468	26.00
27.00	Interim payments		124,265	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)		23,203	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: 141329 | Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-4 | Date/Time Prepared: 11/7/2012 8:46 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)	551,404	551,404	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000185	0.001057	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	102	583	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	869	1,082	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	971	1,665	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,236,761	1,236,761	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	699,123	699,123	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000785	0.001346	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	549	941	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,520	2,606	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	18	103	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	84.44	25.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	11	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	169	278	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)		4,126	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)		447	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-5 | Date/Time Prepared: 11/7/2012 8:46 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		114,667	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		02/24/2012	9,598	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)		9,598	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		124,265	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		23,203	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		147,468	7.00

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