

**ST. VINCENT WILLIAMSPORT HOSPITAL
WILLIAMSPORT, INDIANA**

**PROVIDER NOS. 15-1307, 15-Z307, 15-3993, 15-3994 AND AIM NO.
100270250**

**HOSPITAL STATEMENTS OF REIMBURSABLE COSTS
(MEDICARE AND MEDICAID PROGRAMS)**

June 30, 2011

ST. VINCENT WILLIAMSPORT HOSPITAL

PROVIDER NOS. 15-1307, 15-Z307, 15-3993, 15-3994 AND AIM NO. 100270250

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Trustees
St. Vincent Williamsport Hospital
Williamsport, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Williamsport Hospital (Provider Nos. 15-1307, 15-Z307, 15-3993, 15-3994 and Medicaid No. 100268360) for the year ended June 30, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

Our compilation was limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services, information that is the representation of management. We have not audited or reviewed the report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

The report is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, this report is not designed for those who are not informed about such differences.

This financial information is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purpose.

Bradley Associates

January 26, 2012

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure 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: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/26/2012 5:48 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		Date: 1/26/2012 Time: 5:48 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 ST. VINCENT WILLIAMSPORT HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 1/26/2012 Time: 5:48 pm
 VU101TE5venX6Hbs1Q231LrMLFGsQ0
 dr.M10w6w7ajtK1.D1lfud:5E45Cvc
 kuZE01ueFZ0RAOpg
 PI: Date: 1/26/2012 Time: 5:48 pm
 6Jr2VF6NgtsEC6T6gu7oSuVRX6P.f0
 p8:Ko0g1nqwtLJf8z:4vh2HpW.0GL2
 wgWTNHLphb0eqAw

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

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	179,123	145,627	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-34,130	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	37,314	0	0	10.00
10.01 RURAL HEALTH CLINIC II II	0	0	63,742	0	0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	144,993	246,683	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 412 NORTH MONROE	PO Box:						1.00		
2.00	City: WILLIAMSPORT	State: IN		Zip Code: 47993		County: WARREN		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	ST. VINCENT WILLIAMSPORT HOSPITAL	151307	15	1	07/01/1966	N	O	P	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	ST. VINCENT WILLIAMSPORT SWING BEDS	152307	15		02/01/1988	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	NORTH CLINIC	153993	15		05/06/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	SOUTH CLINIC	153994	15		08/01/2001	N	O	N	15.01
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:			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2010	06/30/2011		20.00	
21.00	Type of Control (see instructions)					6			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 days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00	
									1.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.							2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 07/01/2010
To 06/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
						1.00 2.00 3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
						1.00
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.				N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 5:58 pm	
					1.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
					V 1.00
					XIX 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	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	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			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)			N	106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
					Physical 1.00
					Occupational 2.00
					Speech 3.00
					Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	109.00
					1.00
					2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.			N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			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
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			1	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with ≤ 100 beds that qualifies for the outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.			N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y	121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

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		1.00	2.00			
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)	Y	15H046	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: ST. VINCENT HEALTH	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00130		141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00		
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00		
				1.00		
144.00	Are provider based physicians' costs included in worksheet A?	Y		144.00		
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00		
				1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00		
				Part A	Part B	
				1.00	2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N		N		155.00
156.00	Subprovider - IPF	N		N		156.00
157.00	Subprovider - IRF	N		N		157.00
158.00	Subprovider - Other	N		N		158.00
159.00	SNF	N		N		159.00
160.00	HHA	N		N		160.00
161.00	CMHC	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
		0	1.00	2.00	3.00	4.00
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
				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)			0168.00		
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)			0.00169.00		

		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)			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.	N		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.			11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			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.			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			15.00
		Y/N		
		1.00		
		Part A		
		Y/N	Date	
		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	were home office costs claimed on the cost report?			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.	Y		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
1/26/2012 5:58 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	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	16	5,840	58,008.00	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)		16	5,840	58,008.00	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)		16	5,840	58,008.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.01 RURAL HEALTH CLINIC II	88.01				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		16			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

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation bed and Hospice days)	0	1,785	183	2,417	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	580	0	580	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	72	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,365	183	3,069	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	2,365	183	3,069	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					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	3,248	4,003	14,281	26.00	
26.01 RURAL HEALTH CLINIC II	0	4,912	4,267	17,153	26.01	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	429	28.00	
29.00 Ambulance Trips		518			29.00	
30.00 Employee discount days (see instruction)				9	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 5:58 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	538	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	152.46	0.00	0	538	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	0.00	15.95	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	20.24	0.00			26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	188.65	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

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)	67	760		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)	67	760		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
26.01 RURAL HEALTH CLINIC II				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

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

Provider CCN: 151307
 Component CCN: 153993

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet S-8
 Date/Time Prepared:
 1/26/2012 5:58 pm

Rural Health
 Clinic (RHC) I

Cost

		1.00			
Clinic Address and Identification					
1.00	Street	1731 RINGER LANE		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WILLIAMSPORT IN 47993		2.00	
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award	Date		
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		0	4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00	
7.00	Appalachian Regional Commission		0	7.00	
8.00	Look-Alikes		0	8.00	
9.00	OTHER (SPECIFY)		0	9.00	
9.01			0	9.01	
9.02			0	9.02	
9.03			0	9.03	
9.04			0	9.04	
9.05			0	9.05	
9.06			0	9.06	
9.07			0	9.07	
9.08			0	9.08	
9.09			0	9.09	
9.10			0	9.10	
		1.00	2.00		
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	Clinic	07:30 17:00		11.00	
		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		GCN number	
		1.00	2.00		
14.00	Provider name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151307 Component CCN: 153993	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/26/2012 5:58 pm Cost
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		County			
2.00	City, State, Zip Code, County	WARREN			2.00
		Tuesday		Wednesday	
		from	to	from	to
		5:00	6:00	7:00	8:00
11.00	Facility hours of operations (1) Clinic	07:30	17:00	07:30	17:00

Health Financial Systems

In Lieu of Form CMS-2552-10

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

Provider CCN: 151307
Component CCN: 153993

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-8
Date/Time Prepared:
1/26/2012 5:58 pm
Cost

		Thursday		Friday		
		from	to	from	to	
11.00	Facility hours of operations (1) Clinic	09:00	10:00	11:00	12:00	
		07:30	16:30	07:30	16:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151307 Component CCN: 153993	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/26/2012 5:58 pm Rural Health Clinic (RHC) I Cost
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		Saturday		
		from	to	
11.00	Facility hours of operations (1) Clinic	13:00	14:00	11.00

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

Provider CCN: 151307
 Component CCN: 153994

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet S-8
 Date/Time Prepared:
 1/26/2012 5:58 pm

Rural Health
 Clinic (RHC) II

Cost

				1.00	
Clinic Address and Identification					
1.00	Street	440 W. SONGER LANE			1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	VEEDERSBURG IN 47987			2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
				Grant Award	Date
				1.00	2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				0 4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				0 5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				0 6.00
7.00	Appalachian Regional Commission				0 7.00
8.00	Look-Alikes				0 8.00
9.00	OTHER (SPECIFY)				0 9.00
9.01					0 9.01
9.02					0 9.02
9.03					0 9.03
9.04					0 9.04
9.05					0 9.05
9.06					0 9.06
9.07					0 9.07
9.08					0 9.08
9.09					0 9.09
9.10					0 9.10
				1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N 0 10.00
Facility hours of operations (1)					
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Clinic	07:30 17:00			11.00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N 0 13.00
				Provider name	CCN number
				1.00	2.00
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)				0 0 0 15.00

Health Financial Systems

In Lieu of Form CMS-2552-10

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

Provider CCN: 151307
Component CCN: 153994

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-8
Date/Time Prepared:
1/26/2012 5:58 pm
Cost

		County				
		4.00				
2.00	City, State, Zip Code, County	FOUNTAIN				2.00
		Tuesday		wednesday		
		from	to	from	to	
		5.00	6.00	7.00	8.00	
11.00	Facility hours of operations (1) Clinic	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151307 Component CCN: 153994	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/26/2012 5:58 pm
		Rural Health Clinic (RHC) II	Cost

	Thursday		Friday		
	from	to	from	to	
	9:00	10:00	11:00	12:00	
11.00	Facility hours of operations (1)				11.00
Clinic	07:30	16:30	07:30	16:30	

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

Provider CCN: 151307
 Component CCN: 153994

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet S-8

Date/Time Prepared:
 1/26/2012 5:58 pm

Rural Health
 Clinic (RHC) II

Cost

		Saturday		
		from	to	
11.00	Facility hours of operations (1) Clinic	13:00	14:00	11.00

		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)	0.346662	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,119,343	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,128,848	6.00
7.00	Medicaid cost (line 1 times line 6)	2,817,963	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)	1,698,620	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	27,238	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,698,620	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	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	2,945,590	9,440
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,021,124	3,272
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,021,124	3,272
		1.00	1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,973,445	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	349,164	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,624,281	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,256,401	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,280,797	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,979,417	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		377,310	377,310	-50,980	326,330	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		716,133	716,133	168,955	885,088	2.00
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	180,927	2,921,016	3,101,943	-28,459	3,073,484	4.00
5.00 ADMINISTRATIVE & GENERAL	1,943,730	1,527,283	3,471,013	-185,430	3,285,583	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	102,472	759,839	862,311	-231	862,080	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 HOUSEKEEPING	125,108	63,827	188,935	0	188,935	9.00
10.00 DIETARY	0	20,464	20,464	-27	20,437	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	40,657	50,515	91,172	110,100	201,272	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	14,966	14,966	-5,770	9,196	14.00
15.00 PHARMACY	131,934	322,513	454,447	-298,255	156,192	15.00
16.00 MEDICAL RECORDS & LIBRARY	186,057	32,893	218,950	0	218,950	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,123,364	209,385	1,332,749	-227	1,332,522	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	570,259	203,912	774,171	-30,752	743,419	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	621,923	224,889	846,812	-25,415	821,397	54.00
60.00 LABORATORY	425,734	700,190	1,125,924	0	1,125,924	60.00
65.00 RESPIRATORY THERAPY	65,750	36,200	101,950	-16,048	85,902	65.00
66.00 PHYSICAL THERAPY	252,252	17,715	269,967	-2	269,965	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	106,262	106,262	52,111	158,373	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	45,373	45,373	0	45,373	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	355,980	355,980	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	842,787	148,976	991,763	-65,308	926,455	88.00
88.01 RURAL HEALTH CLINIC II	1,137,741	191,339	1,329,080	-87,005	1,242,075	88.01
91.00 EMERGENCY	1,103,977	680,192	1,784,169	-542	1,783,627	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	397,968	82,197	480,165	-2,342	477,823	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,252,640	9,453,389	18,706,029	-109,647	18,596,382	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	163,977	16,248	180,225	136,197	316,422	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	425,271	74,495	499,766	0	499,766	193.01
194.00 MARKETING	2,402	16,853	19,255	-26,550	-7,295	194.00
200.00 TOTAL (SUM OF LINES 118-199)	9,844,290	9,560,985	19,405,275	0	19,405,275	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description		Adjustments (See A-8) 6:00	Net Expenses For Allocation 7:00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	137,145	463,475	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-42,724	842,364	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	477,140	3,550,624	4.00
5.00	ADMINISTRATIVE & GENERAL	380,583	3,666,166	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	0	862,080	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	HOUSEKEEPING	0	188,935	9.00
10.00	DIETARY	-13,154	7,283	10.00
11.00	CAFETERIA	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	-30	201,242	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	9,196	14.00
15.00	PHARMACY	-2,850	153,342	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	218,950	16.00
17.00	SOCIAL SERVICE	0	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	NURSING SCHOOL	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	PARAMED ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-380	1,332,142	30.00
ANGILIARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-214,274	529,145	50.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-146,045	675,352	54.00
60.00	LABORATORY	0	1,125,924	60.00
65.00	RESPIRATORY THERAPY	0	85,902	65.00
66.00	PHYSICAL THERAPY	-22,952	247,013	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	158,373	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	45,373	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	355,980	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-17	926,438	88.00
88.01	RURAL HEALTH CLINIC II	0	1,242,075	88.01
91.00	EMERGENCY	-131,294	1,652,333	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	477,823	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	421,148	19,017,530	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	316,422	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	ORTHO CLINIC	-395,459	104,307	193.01
194.00	MARKETING	253,174	245,879	194.00
200.00	TOTAL (SUM OF LINES 118-199)	278,863	19,684,138	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	75,251	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	42,724	2.00
	TOTALS		0	117,975	
B - RHC ADMIN TIME					
1.00	ADMINISTRATIVE & GENERAL	5.00	17,190	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	1,500	2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	1,500	3.00
	TOTALS		17,190	3,000	
C - RHC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	136,197	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		136,197	0	
E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	52,111	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	355,980	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
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
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	408,091	
F - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	126,231	1.00
	TOTALS		0	126,231	
G - ADMIN RECLASS					
1.00	NURSING ADMINISTRATION	13.00	110,104	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	28,459	2.00
	TOTALS		110,104	28,459	
500.00	Grand Total: Increases		263,491	683,756	500.00

		Decreases				wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other				
	6.00	7.00	8.00	9.00	10.00			
A - INTEREST								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	117,975	0	10	1.00	
2.00		0.00	0	0	0	10	2.00	
	TOTALS		0	117,975				
B - RHC ADMIN TIME								
1.00	RURAL HEALTH CLINIC	88.00	17,190	0	0	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,000	0	0	2.00	
3.00		0.00	0	0	0	0	3.00	
	TOTALS		17,190	3,000				
C - RHC RECLASS								
1.00	RURAL HEALTH CLINIC	88.00	48,644	0	0	0	1.00	
2.00	RURAL HEALTH CLINIC II	88.01	87,553	0	0	0	2.00	
	TOTALS		136,197	0				
E - MEDICAL SUPPLIES								
1.00	OPERATION OF PLANT	7.00	0	231	0	0	1.00	
2.00	RURAL HEALTH CLINIC II	88.01	0	952	0	0	2.00	
3.00	DIETARY	10.00	0	27	0	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	0	4	0	0	4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,770	0	0	5.00	
6.00	PHARMACY	15.00	0	298,255	0	0	6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	227	0	0	7.00	
8.00	OPERATING ROOM	50.00	0	29,325	0	0	8.00	
9.00	OPERATING ROOM	50.00	0	1,427	0	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	833	0	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,907	0	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,675	0	0	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	16,048	0	0	13.00	
14.00	PHYSICAL THERAPY	66.00	0	2	0	0	14.00	
15.00	RURAL HEALTH CLINIC	88.00	0	974	0	0	15.00	
16.00	EMERGENCY	91.00	0	542	0	0	16.00	
17.00	AMBULANCE SERVICES	95.00	0	2,342	0	0	17.00	
18.00	MARKETING	194.00	0	26,550	0	0	18.00	
	TOTALS		0	408,091				
F - DEPRECIATION								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	126,231	0	10	1.00	
	TOTALS		0	126,231				
G - ADMIN RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	110,104	0	0	0	1.00	
2.00	EMPLOYEE BENEFITS	4.00	0	28,459	0	0	2.00	
	TOTALS		110,104	28,459				
500.00	Grand Total: Decreases		263,491	683,756			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 5:58 pm

	Beginning Balances	Acquisitions			Total	Disposals and Retirements	
		Purchases	Donation				
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	174,050	0	0	0	0	1.00
2.00	Land Improvements	106,181	0	0	0	0	2.00
3.00	Buildings and Fixtures	7,449,699	142,925	0	142,925	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,652,521	658,205	0	658,205	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,382,451	801,130	0	801,130	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,382,451	801,130	0	801,130	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	377,310	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	716,133	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,093,443	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col: 1 - col: 2)	ALLOCATION OF OTHER CAPITAL 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	7,872,855	0	7,872,855	0.646186	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,310,726	0	4,310,726	0.353814	0	2.00
3.00	Total (sum of lines 1-2)	12,183,581	0	12,183,581	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 5:58 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	174,050	0			1.00	
2.00	Land Improvements	106,181	0			2.00	
3.00	Buildings and Fixtures	7,592,624	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	4,310,726	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	12,183,581	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	12,183,581	0			10.00	
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	377,310			1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	716,133			2.00	
3.00	Total (sum of lines 1-2)	0	1,093,443			3.00	
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL 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	377,310	86,165	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	716,133	126,231	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,093,443	212,396	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	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	0	0	0	0	463,475	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	842,364	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,305,839	3.00

Provider CCN: 151307

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet A-8
 Date/Time Prepared:
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		Expense Classification on worksheet A To/From which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)	B	-25,253	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)	B	-14,338	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-14,648	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-887,072		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	1,313,244		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests		0		0.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00 33.00
34.00	DONATIONS	A	-5,000	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00	CHARITABLE CONTRIBUTIONS	A	-5,207	ADMINISTRATIVE & GENERAL	5.00 35.00
35.01	CHARITABLE CONTRIBUTIONS	A	-300	EMPLOYEE BENEFITS	4.00 35.01
36.00	LOBBYING	A	-705	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00	INCENTIVE PAYROLL	A	99,000	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00	SERVICING FEES BY MINISTRY	A	23,467	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00	CREDENTIALING	B	-4,550	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00	MISC	B	-32,060	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00	AP REFUNDS	B	-7,800	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00	INTEREST	B	-289	ADMINISTRATIVE & GENERAL	5.00 42.00
43.00	PHARMACY	B	-2,850	PHARMACY	15.00 43.00
44.00	MEDICAL DIRECTOR FEE REVENUE	B	-10,200	ADMINISTRATIVE & GENERAL	5.00 44.00
44.01	PHYSICAL THERAPY	B	-22,925	PHYSICAL THERAPY	66.00 44.01
44.02	FOOD SERVICES	B	-13,154	DIETARY	10.00 44.02
44.03	STALE DATED CHECKS	B	-37,051	ADMINISTRATIVE & GENERAL	5.00 44.03
44.04	CLOSED BANK ACCOUNT	B	-6,514	ADMINISTRATIVE & GENERAL	5.00 44.04
45.00	MARKETING	A	-313	ADMINISTRATIVE & GENERAL	5.00 45.00
45.02	COMMUNITY BENEFIT	A	-30	NURSING ADMINISTRATION	13.00 45.02
45.03	COMMUNITY BENEFIT	A	-55	EMPLOYEE BENEFITS	4.00 45.03

Provider CCN: 151307

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet A-8

Date/Time Prepared:
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		Expense Classification on worksheet A To/From which the Amount is to be Adjusted				
	Basis/Code (2)	Amount	Cost Center	Line #		
	1.00	2.00	3.00	4.00		
45.05	COMMUNITY BENEFIT	A	-1,895	ADMINISTRATIVE & GENERAL	5.00	45.05
45.10	COMMUNITY BENEFIT	A	-380	ADULTS & PEDIATRICS	30.00	45.10
45.25	GIFTS	A	-5,215	ADMINISTRATIVE & GENERAL	5.00	45.25
45.26			0		0.00	45.26
45.27	CRNA	A	-58,319	EMPLOYEE BENEFITS	4.00	45.27
46.03	NON-ALLOWABLE EXPENSE	A	-27	PHYSICAL THERAPY	66.00	46.03
46.04	NON-ALLOWABLE EXPENSE	A	-17	RURAL HEALTH CLINIC	88.00	46.04
46.05	NON-ALLOWABLE EXPENSE	A	-230	ADMINISTRATIVE & GENERAL	5.00	46.05
46.06	TRAVEL	A	-451	ADMINISTRATIVE & GENERAL	5.00	46.06
46.07			0		0.00	46.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		278,863			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
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		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	10	1.00
2.00	Investment income - movable equipment (chapter 2)	10	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	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	OTHER ADJUSTMENTS (SPECIFY)	0	33.00
34.00	DONATIONS	0	34.00
35.00	CHARITABLE CONTRIBUTIONS	0	35.00
35.01	CHARITABLE CONTRIBUTIONS	0	35.01
36.00	LOBBYING	0	36.00
37.00	INCENTIVE PAYROLL	0	37.00
38.00	SERVICING FEES BY MINISTRY	0	38.00
39.00	CREDENTIALING	0	39.00
40.00	MISC	0	40.00
41.00	AP REFUNDS	0	41.00
42.00	INTEREST	0	42.00
43.00	PHARMACY	0	43.00
44.00	MEDICAL DIRECTOR FEE REVENUE	0	44.00
44.01	PHYSICAL THERAPY	0	44.01
44.02	FOOD SERVICES	0	44.02
44.03	STALE DATED CHECKS	0	44.03
44.04	CLOSED BANK ACCOUNT	0	44.04
45.00	MARKETING	0	45.00
45.02	COMMUNITY BENEFIT	0	45.02
45.03	COMMUNITY BENEFIT	0	45.03
45.05	COMMUNITY BENEFIT	0	45.05
45.10	COMMUNITY BENEFIT	0	45.10
45.25	GIFTS	0	45.25
45.26		0	45.26
45.27	CRNA	0	45.27
46.03	NON-ALLOWABLE EXPENSE	0	46.03
46.04	NON-ALLOWABLE EXPENSE	0	46.04
46.05	NON-ALLOWABLE EXPENSE	0	46.05

Provider CCN: 151307

Period:
 From 07/01/2010
 To 06/30/2011

Worksheet A-8

Date/Time Prepared:
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		Wkst. A-7 Ref.	
46.06	TRAVEL	5.00	0
46.07			0
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		
			46.06
			46.07
			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
1/26/2012 5:58 pm

	Line No.		Cost Center	Expense Items	
	1.00	2.00			
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	EMPLOYEE BENEFITS	PENSION	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	ASCENSION - MAINTENANCE	2.00
3.00		1.00	NEW CAP REL COSTS-BLDG & FIXT	ST. VINCENT HEALTH	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH	4.00
4.01		4.00	EMPLOYEE BENEFITS	ST. VINCENT HEALTH	4.01
4.02		7.00	OPERATION OF PLANT	ST. VINCENT HEALTH - CHGB	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHGB	4.03
4.04		4.00	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - CHGB	4.04
4.05		54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH - CHGB	4.05
4.06		30.00	ADULTS & PEDIATRICS	ST. VINCENT HEALTH - CHGB	4.06
4.07		16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHGB	4.07
4.08		15.00	PHARMACY	ST. VINCENT HEALTH - CHGB	4.08
4.09		14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HEALTH - CHGB	4.09
4.10		66.00	PHYSICAL THERAPY	ST. VINCENT HEALTH - CHGB	4.10
4.11		91.00	EMERGENCY	ST. VINCENT HEALTH - CHGB	4.11
4.12		194.00	MARKETING	ST. VINCENT CHGB	4.12
4.13		1.00	NEW CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.13
4.14		2.00	NEW CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	4.14
4.15		5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.15
4.16		5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	4.16
4.17		194.00	MARKETING	ST. VINCENT HEALTH	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)		Name	Percentage of Ownership	
	1.00	2.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		G	SVH	100.00		6.00
7.00		B	ASCENSION	100.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:		HOME OFFICE			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
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	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	539,076	539,076	0	0	1.00
2.00	218,492	234,836	-16,344	0	2.00
3.00	212,396	0	212,396	10	3.00
4.00	1,733,888	1,298,299	435,589	0	4.00
4.01	1,655,588	1,119,774	535,814	0	4.01
4.02	116,700	116,700	0	0	4.02
4.03	2,119,614	2,119,614	0	0	4.03
4.04	371,043	371,043	0	0	4.04
4.05	18,444	18,444	0	0	4.05
4.06	45,819	45,819	0	0	4.06
4.07	26,820	26,820	0	0	4.07
4.08	3,564	3,564	0	0	4.08
4.09	862	862	0	0	4.09
4.10	-3,903	-3,903	0	0	4.10
4.11	44	44	0	0	4.11
4.12	380	380	0	0	4.12
4.13	25,253	75,251	-49,998	10	4.13
4.14	14,338	42,724	-28,386	10	4.14
4.15	14,648	43,649	-29,001	0	4.15
4.16	128,217	128,217	0	0	4.16
4.17	253,174	0	253,174	0	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	7,494,457	6,181,213	1,313,244	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	ST. VINCENT HEALTH	100.00	ADMINISTRATION	6.00
7.00	ASCENSION	100.00	ADMINISTRATION	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. other (financial or non-financial) specify:			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 5:58 pm

	Wkst. A	Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00		2.00	3.00	4.00	
1.00		50.00	ANESTHESIOLOGY	214,274	214,274	1.00
2.00		54.00	RADIOLOGY	147,645	146,045	2.00
3.00		91.00	ER - SALARY	894,233	131,294	3.00
4.00		193.01	ORTHOPEDECS	395,459	395,459	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,651,611	887,072	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 5:58 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	1,600	0	0	0	0	2.00
3.00	762,939	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	764,539					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 5:58 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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 5:58 pm

	RCE	Adjustment	
	Disallowance		
	17:00	18:00	
1.00	0	214,274	1.00
2.00	0	146,045	2.00
3.00	0	131,294	3.00
4.00	0	395,459	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	887,072	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 5:58 pm
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		Physical Therapy					Cost
							1.00
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					17	1.00
2.00	Line 1 multiplied by 15 hours per week					255	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					31	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)					16	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					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	391.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.79	54.94	24.78	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)	35.40	35.40	27.47			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)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					21,482	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					21,482	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)					21,482	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					21,482	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)					1,097	24.00
25.00	Assistants (line 4 times column 3, line 11)					440	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,537	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)					259	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,796	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)					0	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: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 5:58 pm
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		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	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	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)	70.79	54.94	24.78	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)					21,482	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					21,482	63.00
64.00	Total cost of outside supplier services (from your records)					20,563	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					1,537	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					259	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,796	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					259	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					259	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 Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		1-00	2-00	4-00			
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	463,475	463,475				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	842,364		842,364			2.00
4.00	EMPLOYEE BENEFITS	3,550,624	0	0	3,550,624		4.00
5.00	ADMINISTRATIVE & GENERAL	3,666,166	38,005	69,074	680,047	4,453,292	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	862,080	66,665	121,165	37,651	1,087,561	7.00
8.00	LAUNDRY & LINEN SERVICE	0	1,871	3,400	0	5,271	8.00
9.00	HOUSEKEEPING	188,935	463	842	45,969	236,209	9.00
10.00	DIETARY	7,283	0	0	0	7,283	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	201,242	4,962	9,019	55,394	270,617	13.00
14.00	CENTRAL SERVICES & SUPPLY	9,196	0	0	0	9,196	14.00
15.00	PHARMACY	153,342	0	0	48,477	201,819	15.00
16.00	MEDICAL RECORDS & LIBRARY	218,950	15,947	28,983	68,363	332,243	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,332,142	56,794	103,223	412,760	1,904,919	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	529,145	38,958	70,807	209,531	848,441	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	675,352	26,548	48,252	228,514	978,666	54.00
60.00	LABORATORY	1,125,924	13,292	24,158	156,428	1,319,802	60.00
65.00	RESPIRATORY THERAPY	85,902	8,054	14,637	24,159	132,752	65.00
66.00	PHYSICAL THERAPY	247,013	18,210	33,096	92,685	391,004	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,373	4,998	9,084	0	172,455	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	45,373	0	0	0	45,373	72.00
73.00	DRUGS CHARGED TO PATIENTS	355,980	4,232	7,691	0	367,903	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	926,438	40,731	74,029	303,351	1,344,549	88.00
88.01	RURAL HEALTH CLINIC II	1,242,075	58,549	106,413	418,042	1,825,079	88.01
91.00	EMERGENCY	1,652,333	22,994	41,791	405,636	2,122,754	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	477,823	26,121	47,474	146,226	697,644	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,017,530	447,394	813,138	3,333,233	18,754,832	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	316,422	11,644	21,163	60,250	409,479	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ORTHO CLINIC	104,307	4,419	8,031	156,258	273,015	193.01
194.00	MARKETING	245,879	18	32	883	246,812	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	19,684,138	463,475	842,364	3,550,624	19,684,138	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description		ADMINISTRATIVE & GENERAL 5:00	MAINTENANCE & REPAIRS 6:00	OPERATION OF PLANT 7:00	LAUNDRY & LINEN SERVICE 8:00	HOUSEKEEPING 9:00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,453,292					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	317,988	0	1,405,549			7.00
8.00	LAUNDRY & LINEN SERVICE	1,541	0	7,329	14,141		8.00
9.00	HOUSEKEEPING	69,064	0	1,815	0	307,088	9.00
10.00	DIETARY	2,129	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	79,125	0	19,439	0	4,275	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,689	0	0	0	0	14.00
15.00	PHARMACY	59,009	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	97,143	0	62,469	0	13,738	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	556,972	0	222,480	7,071	48,926	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	248,072	0	152,612	2,121	33,561	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	286,148	0	103,998	707	22,871	54.00
60.00	LABORATORY	385,892	0	52,069	0	11,451	60.00
65.00	RESPIRATORY THERAPY	38,815	0	31,549	0	6,938	65.00
66.00	PHYSICAL THERAPY	114,324	0	71,333	707	15,687	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,423	0	19,578	0	4,306	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	13,266	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	107,570	0	16,577	0	3,645	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	393,127	0	159,557	385	35,089	88.00
88.01	RURAL HEALTH CLINIC II	533,628	0	229,354	322	50,438	88.01
91.00	EMERGENCY	620,670	0	90,074	2,828	19,808	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	203,981	0	102,323	0	22,502	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,181,576	0	1,342,556	14,141	293,235	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	119,726	0	45,613	0	10,031	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ORTHO CLINIC	79,826	0	17,310	0	3,807	193.01
194.00	MARKETING	72,164	0	70	0	15	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,453,292	0	1,405,549	14,141	307,088	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	9,412					10.00
11.00 CAFETERIA	0	0				11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00 NURSING ADMINISTRATION	0	0	0	373,456		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	11,885	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9,412	0	0	147,998	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	49,672	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	65,234	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	10,874	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,885	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	99,678	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,412	0	0	373,456	11,885	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	0	0	0	0	0	193.01
194.00 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	9,412	0	0	373,456	11,885	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151307

Period:
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
	15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	260,828					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	505,593				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	24,758	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	31,101	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	116,595	0	0	0	54.00
60.00 LABORATORY	0	125,588	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	12,590	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	18,471	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,387	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	2,180	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	260,828	24,084	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	19,305	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	23,366	0	0	0	88.01
91.00 EMERGENCY	0	80,130	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	14,038	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	260,828	505,593	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	0	0	0	0	0	193.01
194.00 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	260,828	505,593	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151307

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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY						15.00
16.00 MEDICAL RECORDS & LIBRARY						16.00
17.00 SOCIAL SERVICE						17.00
19.00 NONPHYSICIAN ANESTHETISTS						19.00
20.00 NURSING SCHOOL						20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00 PARAMED ED PRGM	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	2,922,536	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	1,365,580	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	1,508,985	0	54.00
60.00 LABORATORY	0	0	0	1,960,036	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	233,518	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	611,526	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	272,034	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	60,819	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	780,607	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	1,952,012	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	2,662,187	0	88.01
91.00 EMERGENCY	0	0	0	3,035,942	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	1,040,488	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	18,406,270	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	584,849	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	0	0	0	373,958	0	193.01
194.00 MARKETING	0	0	0	319,061	0	194.00
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	0	0	19,684,138	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center	Description	Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
6.00	MAINTENANCE & REPAIRS		6.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
12.00	MAINTENANCE OF PERSONNEL		12.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
19.00	NONPHYSICIAN ANESTHETISTS		19.00
20.00	NURSING SCHOOL		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	PARAMED ED PRGM		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,922,536	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	1,365,580	50.00
53.00	ANESTHESIOLOGY	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,508,985	54.00
60.00	LABORATORY	1,960,036	60.00
65.00	RESPIRATORY THERAPY	233,518	65.00
66.00	PHYSICAL THERAPY	611,526	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	272,034	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	60,819	72.00
73.00	DRUGS CHARGED TO PATIENTS	780,607	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	1,952,012	88.00
88.01	RURAL HEALTH CLINIC II	2,662,187	88.01
91.00	EMERGENCY	3,035,942	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	1,040,488	95.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,406,270	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	584,849	192.00
193.00	NONPAID WORKERS	0	193.00
193.01	ORTHO CLINIC	373,958	193.01
194.00	MARKETING	319,061	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	19,684,138	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151307

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		NEW BLDG & FIXT	NEW MVBLE EQUIP		
	0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS	0	0	0	0	0 4.00
5.00 ADMINISTRATIVE & GENERAL	0	38,005	69,074	107,079	0 5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 OPERATION OF PLANT	0	66,665	121,165	187,830	0 7.00
8.00 LAUNDRY & LINEN SERVICE	0	1,871	3,400	5,271	0 8.00
9.00 HOUSEKEEPING	0	463	842	1,305	0 9.00
10.00 DIETARY	0	0	0	0	0 10.00
11.00 CAFETERIA	0	0	0	0	0 11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 NURSING ADMINISTRATION	0	4,962	9,019	13,981	0 13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 PHARMACY	0	0	0	0	0 15.00
16.00 MEDICAL RECORDS & LIBRARY	0	15,947	28,983	44,930	0 16.00
17.00 SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 NURSING SCHOOL	0	0	0	0	0 20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 PARAMED ED PRGM	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	56,794	103,223	160,017	0 30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	38,958	70,807	109,765	0 50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	26,548	48,252	74,800	0 54.00
60.00 LABORATORY	0	13,292	24,158	37,450	0 60.00
65.00 RESPIRATORY THERAPY	0	8,054	14,637	22,691	0 65.00
66.00 PHYSICAL THERAPY	0	18,210	33,096	51,306	0 66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,998	9,084	14,082	0 71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,232	7,691	11,923	0 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	40,731	74,029	114,760	0 88.00
88.01 RURAL HEALTH CLINIC II	0	58,549	106,413	164,962	0 88.01
91.00 EMERGENCY	0	22,994	41,791	64,785	0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	26,121	47,474	73,595	0 95.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	447,394	813,138	1,260,532	0 118.00
NONREIMBURSABLE COST CENTERS					
192.00 PHYSICIANS' PRIVATE OFFICES	0	11,644	21,163	32,807	0 192.00
193.00 NONPAID WORKERS	0	0	0	0	0 193.00
193.01 ORTHO CLINIC	0	4,419	8,031	12,450	0 193.01
194.00 MARKETING	0	18	32	50	0 194.00
200.00 Cross Foot Adjustments				0	0 200.00
201.00 Negative Cost Centers	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	0	463,475	842,364	1,305,839	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	107,079					5.00
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	7,646	0	195,476			7.00
8.00 LAUNDRY & LINEN SERVICE	37	0	1,019	6,327		8.00
9.00 HOUSEKEEPING	1,661	0	252	0	3,218	9.00
10.00 DIETARY	51	0	0	0	0	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	1,902	0	2,703	0	45	13.00
14.00 CENTRAL SERVICES & SUPPLY	65	0	0	0	0	14.00
15.00 PHARMACY	1,419	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	2,336	0	8,688	0	144	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	13,392	0	30,941	3,165	513	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,965	0	21,224	949	352	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	6,880	0	14,464	316	240	54.00
60.00 LABORATORY	9,278	0	7,241	0	120	60.00
65.00 RESPIRATORY THERAPY	933	0	4,388	0	73	65.00
66.00 PHYSICAL THERAPY	2,749	0	9,921	316	164	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,212	0	2,723	0	45	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	319	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,586	0	2,305	0	38	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	9,452	0	22,190	172	368	88.00
88.01 RURAL HEALTH CLINIC II	12,830	0	31,898	144	527	88.01
91.00 EMERGENCY	14,929	0	12,527	1,265	208	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	4,904	0	14,231	0	236	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	100,546	0	186,715	6,327	3,073	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	2,879	0	6,344	0	105	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	1,919	0	2,407	0	40	193.01
194.00 MARKETING	1,735	0	10	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	107,079	0	195,476	6,327	3,218	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	51					10.00
11.00 CAFETERIA	0	0				11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00 NURSING ADMINISTRATION	0	0	0	18,631		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	65	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	51	0	0	7,384	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	2,478	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	3,254	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	542	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	65	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	4,973	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	51	0	0	18,631	65	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	0	0	0	0	0	193.01
194.00 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	51	0	0	18,631	65	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
	15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	1,419					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	56,098				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00 NURSING SCHOOL	0	0	0		0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00 PARAMED ED PRGM	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	2,748	0			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	3,452	0			50.00
53.00 ANESTHESIOLOGY	0	0	0			53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	12,941	0			54.00
60.00 LABORATORY	0	13,920	0			60.00
65.00 RESPIRATORY THERAPY	0	1,397	0			65.00
66.00 PHYSICAL THERAPY	0	2,050	0			66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,486	0			71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	242	0			72.00
73.00 DRUGS CHARGED TO PATIENTS	1,419	2,673	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,143	0			88.00
88.01 RURAL HEALTH CLINIC II	0	2,594	0			88.01
91.00 EMERGENCY	0	8,894	0			91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	1,558	0			95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,419	56,098	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
193.00 NONPAID WORKERS	0	0	0			193.00
193.01 ORTHO CLINIC	0	0	0			193.01
194.00 MARKETING	0	0	0			194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	1,419	56,098	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS					
	21.00	22.00	23.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE						17.00
19.00	NONPHYSICIAN ANESTHETISTS						19.00
20.00	NURSING SCHOOL						20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
23.00	PARAMED ED PRGM			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS				218,211	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM				144,185	0	50.00
53.00	ANESTHESIOLOGY				0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC				109,641	0	54.00
60.00	LABORATORY				71,263	0	60.00
65.00	RESPIRATORY THERAPY				30,024	0	65.00
66.00	PHYSICAL THERAPY				66,506	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS				19,613	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT				561	0	72.00
73.00	DRUGS CHARGED TO PATIENTS				20,944	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC				149,085	0	88.00
88.01	RURAL HEALTH CLINIC II				212,955	0	88.01
91.00	EMERGENCY				107,581	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER				0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES				94,524	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	1,245,093	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES				42,135	0	192.00
193.00	NONPAID WORKERS				0	0	193.00
193.01	ORTHO CLINIC				16,816	0	193.01
194.00	MARKETING				1,795	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	1,305,839	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151307

Period:
From 07/01/2010
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Worksheet B
Part II
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Cost Center Description	Total	
	26.00	
GENERAL SERVICE COST CENTERS		
1.00 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00 EMPLOYEE BENEFITS		4.00
5.00 ADMINISTRATIVE & GENERAL		5.00
6.00 MAINTENANCE & REPAIRS		6.00
7.00 OPERATION OF PLANT		7.00
8.00 LAUNDRY & LINEN SERVICE		8.00
9.00 HOUSEKEEPING		9.00
10.00 DIETARY		10.00
11.00 CAFETERIA		11.00
12.00 MAINTENANCE OF PERSONNEL		12.00
13.00 NURSING ADMINISTRATION		13.00
14.00 CENTRAL SERVICES & SUPPLY		14.00
15.00 PHARMACY		15.00
16.00 MEDICAL RECORDS & LIBRARY		16.00
17.00 SOCIAL SERVICE		17.00
19.00 NONPHYSICIAN ANESTHETISTS		19.00
20.00 NURSING SCHOOL		20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00 PARAMED ED PRGM		23.00
INPATIENT ROUTINE SERVICE COST CENTERS		
30.00 ADULTS & PEDIATRICS	218,211	30.00
ANCILLARY SERVICE COST CENTERS		
50.00 OPERATING ROOM	144,185	50.00
53.00 ANESTHESIOLOGY	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	109,641	54.00
60.00 LABORATORY	71,263	60.00
65.00 RESPIRATORY THERAPY	30,024	65.00
66.00 PHYSICAL THERAPY	66,506	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,613	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	561	72.00
73.00 DRUGS CHARGED TO PATIENTS	20,944	73.00
OUTPATIENT SERVICE COST CENTERS		
88.00 RURAL HEALTH CLINIC	149,085	88.00
88.01 RURAL HEALTH CLINIC II	212,955	88.01
91.00 EMERGENCY	107,581	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS		
95.00 AMBULANCE SERVICES	94,524	95.00
SPECIAL PURPOSE COST CENTERS		
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,245,093	118.00
NONREIMBURSABLE COST CENTERS		
192.00 PHYSICIANS' PRIVATE OFFICES	42,135	192.00
193.00 NONPAID WORKERS	0	193.00
193.01 ORTHO CLINIC	16,816	193.01
194.00 MARKETING	1,795	194.00
200.00 Cross Foot Adjustments	0	200.00
201.00 Negative Cost Centers	0	201.00
202.00 TOTAL (sum lines 118-201)	1,305,839	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00	5A	5.00		
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	52,024						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		52,024					2.00
4.00 EMPLOYEE BENEFITS	0	0	9,663,363				4.00
5.00 ADMINISTRATIVE & GENERAL	4,266	4,266	1,850,816	-4,453,292	15,230,846		5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0		6.00
7.00 OPERATION OF PLANT	7,483	7,483	102,472	0	1,087,561		7.00
8.00 LAUNDRY & LINEN SERVICE	210	210	0	0	5,271		8.00
9.00 HOUSEKEEPING	52	52	125,108	0	236,209		9.00
10.00 DIETARY	0	0	0	0	7,283		10.00
11.00 CAFETERIA	0	0	0	0	0		11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0		12.00
13.00 NURSING ADMINISTRATION	557	557	150,761	0	270,617		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	9,196		14.00
15.00 PHARMACY	0	0	131,934	0	201,819		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,790	1,790	186,057	0	332,243		16.00
17.00 SOCIAL SERVICE	0	0	0	0	0		17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0		19.00
20.00 NURSING SCHOOL	0	0	0	0	0		20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0		22.00
23.00 PARAMED ED PRGM	0	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	6,375	6,375	1,123,364	0	1,904,919		30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	4,373	4,373	570,259	0	848,441		50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,980	2,980	621,923	0	978,666		54.00
60.00 LABORATORY	1,492	1,492	425,734	0	1,319,802		60.00
65.00 RESPIRATORY THERAPY	904	904	65,750	0	132,752		65.00
66.00 PHYSICAL THERAPY	2,044	2,044	252,252	0	391,004		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	172,455		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	45,373		72.00
73.00 DRUGS CHARGED TO PATIENTS	475	475	0	0	367,903		73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	4,572	4,572	825,597	0	1,344,549		88.00
88.01 RURAL HEALTH CLINIC II	6,572	6,572	1,137,741	0	1,825,079		88.01
91.00 EMERGENCY	2,581	2,581	1,103,977	0	2,122,754		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	2,932	2,932	397,968	0	697,644		95.00
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES 1-117)	50,219	50,219	9,071,713	-4,453,292	14,301,540		118.00
NONREIMBURSABLE COST CENTERS							
192.00 PHYSICIANS' PRIVATE OFFICES	1,307	1,307	163,977	0	409,479		192.00
193.00 NONPAID WORKERS	0	0	0	0	0		193.00
193.01 ORTHO CLINIC	496	496	425,271	0	273,015		193.01
194.00 MARKETING	2	2	2,402	0	246,812		194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	463,475	842,364	3,550,624		4,453,292		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	8.908869	16.191835	0.367432		0.292386		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		107,079		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007030		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS	0					6.00
7.00 OPERATION OF PLANT	0	40,275				7.00
8.00 LAUNDRY & LINEN SERVICE	0	210	80,518			8.00
9.00 HOUSEKEEPING	0	52	0	40,013		9.00
10.00 DIETARY	0	0	0	0	100	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	557	0	557	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	1,790	0	1,790	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	6,375	40,259	6,375	100	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	4,373	12,078	4,373	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,980	4,026	2,980	0	54.00
60.00 LABORATORY	0	1,492	0	1,492	0	60.00
65.00 RESPIRATORY THERAPY	0	904	0	904	0	65.00
66.00 PHYSICAL THERAPY	0	2,044	4,026	2,044	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	561	0	561	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	475	0	475	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	4,572	2,193	4,572	0	88.00
88.01 RURAL HEALTH CLINIC II	0	6,572	1,832	6,572	0	88.01
91.00 EMERGENCY	0	2,581	16,104	2,581	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	2,932	0	2,932	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	38,470	80,518	38,208	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	1,307	0	1,307	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 ORTHO CLINIC	0	496	0	496	0	193.01
194.00 MARKETING	0	2	0	2	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	0	1,405,549	14,141	307,088	9,412	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.000000	34.898796	0.175625	7.674706	94.120000	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	0	195,476	6,327	3,218	51	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000000	4.853532	0.078579	0.080424	0.510000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

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Date/Time Prepared:
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Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	0					11.00
12.00	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	NURSING ADMINISTRATION	0	0	129,341			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	100		14.00
15.00	PHARMACY	0	0	0	0	100	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	51,257	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	17,203	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	22,593	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	3,766	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	EMERGENCY	0	0	34,522	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	129,341	100	100	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	ORTHO CLINIC	0	0	0	0	0	193.01
194.00	MARKETING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	0	0	373,456	11,885	260,828	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	2.887375	118.850000	2,608.280000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	0	18,631	65	1,419	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.144046	0.650000	14.190000	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
12.00	MAINTENANCE OF PERSONNEL					12.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY	53,754,247				16.00
17.00	SOCIAL SERVICE	0	0			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00	NURSING SCHOOL	0	0		0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
23.00	PARAMED ED PRGM	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,632,110	0		0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,306,527	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	12,395,771	0	0	0	54.00
60.00	LABORATORY	13,354,085	0	0	0	60.00
65.00	RESPIRATORY THERAPY	1,338,530	0	0	0	65.00
66.00	PHYSICAL THERAPY	1,963,747	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,423,201	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	231,802	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,560,462	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,052,364	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	2,484,211	0	0	0	88.01
91.00	EMERGENCY	8,518,993	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1,492,444	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	53,754,247	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	ORTHO CLINIC	0	0	0	0	193.01
194.00	MARKETING	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	505,593	0	0	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.009406	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	56,098	0	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.001044	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
12.00	MAINTENANCE OF PERSONNEL				12.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
19.00	NONPHYSICIAN ANESTHETISTS				19.00
20.00	NURSING SCHOOL				20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00	PARAMED ED PRGM			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0	0	30.00
ANGILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	LABORATORY	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	88.01
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
193.01	ORTHO CLINIC	0	0	0	193.01
194.00	MARKETING	0	0	0	194.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	Total Costs	
			Total Costs	RCE Disallowance			
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,922,536		2,922,536	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,365,580		1,365,580	0	0	50.00
53.00	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,508,985		1,508,985	0	0	54.00
60.00	LABORATORY	1,960,036		1,960,036	0	0	60.00
65.00	RESPIRATORY THERAPY	233,518	0	233,518	0	0	65.00
66.00	PHYSICAL THERAPY	611,526	0	611,526	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	272,034		272,034	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	60,819		60,819	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	780,607		780,607	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	1,952,012		1,952,012	0	0	88.00
88.01	RURAL HEALTH CLINIC II	2,662,187		2,662,187	0	0	88.01
91.00	EMERGENCY	3,035,942		3,035,942	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	364,581		364,581	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	1,040,488		1,040,488	0	0	95.00
200.00	Subtotal (see instructions)	18,770,851	0	18,770,851	0	0	200.00
201.00	Less Observation Beds	364,581		364,581			201.00
202.00	Total (see instructions)	18,406,270	0	18,406,270	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Hospital	Cost	
	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,632,110		2,632,110			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	264,254	3,042,273	3,306,527	0.412995	0.000000	50.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,076,626	11,319,145	12,395,771	0.121734	0.000000	54.00
60.00 LABORATORY	1,610,439	11,743,646	13,354,085	0.146774	0.000000	60.00
65.00 RESPIRATORY THERAPY	562,384	776,145	1,338,529	0.174459	0.000000	65.00
66.00 PHYSICAL THERAPY	502,689	1,461,058	1,963,747	0.311408	0.000000	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	584,222	838,979	1,423,201	0.191142	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	139,969	91,833	231,802	0.262375	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,227,254	1,333,208	2,560,462	0.304870	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,052,364	2,052,364			88.00
88.01 RURAL HEALTH CLINIC II	0	2,484,211	2,484,211			88.01
91.00 EMERGENCY	310,943	8,208,050	8,518,993	0.356373	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	393,156	393,156	0.927319	0.000000	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	159,988	1,332,456	1,492,444	0.697171	0.000000	95.00
200.00 Subtotal (see instructions)	9,070,878	45,076,524	54,147,402			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9,070,878	45,076,524	54,147,402			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Title XVIII

Hospital

Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00 LABORATORY	0.000000		60.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC			88.00
88.01 RURAL HEALTH CLINIC II			88.01
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	0.000000		95.00
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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
				RCE	Disallowance		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		2,922,536		0	2,922,536	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		1,365,580		0	1,365,580	50.00
53.00	ANESTHESIOLOGY		0		0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		1,508,985		0	1,508,985	54.00
60.00	LABORATORY		1,960,036		0	1,960,036	60.00
65.00	RESPIRATORY THERAPY	0	233,518		0	233,518	65.00
66.00	PHYSICAL THERAPY	0	611,526		0	611,526	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		272,034		0	272,034	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		60,819		0	60,819	72.00
73.00	DRUGS CHARGED TO PATIENTS		780,607		0	780,607	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		1,952,012		0	1,952,012	88.00
88.01	RURAL HEALTH CLINIC II		2,662,187		0	2,662,187	88.01
91.00	EMERGENCY		3,035,942		0	3,035,942	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		365,958		0	365,958	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER		0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES		1,040,488		0	1,040,488	95.00
200.00	Subtotal (see instructions)		18,772,228	0	0	18,772,228	200.00
201.00	Less Observation Beds		365,958		0	365,958	201.00
202.00	Total (see instructions)		18,406,270	0	0	18,406,270	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,632,110		2,632,110			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	264,254	3,042,273	3,306,527	0.412995	0.000000	50.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,076,626	11,319,145	12,395,771	0.121734	0.000000	54.00
60.00 LABORATORY	1,610,439	11,743,646	13,354,085	0.146774	0.000000	60.00
65.00 RESPIRATORY THERAPY	562,384	776,145	1,338,529	0.174459	0.000000	65.00
66.00 PHYSICAL THERAPY	502,689	1,461,058	1,963,747	0.311408	0.000000	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	584,222	838,979	1,423,201	0.191142	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	139,969	91,833	231,802	0.262375	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,227,254	1,333,208	2,560,462	0.304870	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,052,364	2,052,364	0.951104	0.000000	88.00
88.01 RURAL HEALTH CLINIC II	0	2,484,211	2,484,211	1.071643	0.000000	88.01
91.00 EMERGENCY	310,943	8,208,050	8,518,993	0.356373	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	393,156	393,156	0.930821	0.000000	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	159,988	1,332,456	1,492,444	0.697171	0.000000	95.00
200.00 Subtotal (see instructions)	9,070,878	45,076,524	54,147,402			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9,070,878	45,076,524	54,147,402			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Title XIX

Hospital

PPS

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.412995		50.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.121734		54.00
60.00 LABORATORY	0.146774		60.00
65.00 RESPIRATORY THERAPY	0.174459		65.00
66.00 PHYSICAL THERAPY	0.311408		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.262375		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.304870		73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0.951104		88.00
88.01 RURAL HEALTH CLINIC II	1.071643		88.01
91.00 EMERGENCY	0.356373		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.930821		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	0.697171		95.00
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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part II
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description		Title XVIII			Hospital		Capital Costs (column 3 x column 4)	
		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	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	144,185	3,306,527	0.043606	118,165	5,153		50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	109,641	12,395,771	0.008845	578,683	5,118		54.00
60.00	LABORATORY	71,263	13,354,085	0.005336	984,502	5,253		60.00
65.00	RESPIRATORY THERAPY	30,024	1,338,529	0.022431	390,875	8,768		65.00
66.00	PHYSICAL THERAPY	66,506	1,963,747	0.033867	217,307	7,360		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,613	1,423,201	0.013781	448,162	6,176		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	561	231,802	0.002420	12,923	31		72.00
73.00	DRUGS CHARGED TO PATIENTS	20,944	2,560,462	0.008180	714,343	5,843		73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	149,085	2,052,364	0.072641	0	0		88.00
88.01	RURAL HEALTH CLINIC II	212,955	2,484,211	0.085723	0	0		88.01
91.00	EMERGENCY	107,581	8,518,993	0.012628	2,294	29		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	393,156	0.000000	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0		93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES							95.00
200.00	Total (lines 50-199)	932,358	50,022,848		3,467,254	43,731		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES							95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
		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)	Cost		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	3,306,527	0.000000	0.000000	118,165	50.00	
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	0	12,395,771	0.000000	0.000000	578,683	54.00	
60.00 LABORATORY	0	13,354,085	0.000000	0.000000	984,502	60.00	
65.00 RESPIRATORY THERAPY	0	1,338,529	0.000000	0.000000	390,875	65.00	
66.00 PHYSICAL THERAPY	0	1,963,747	0.000000	0.000000	217,307	66.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,423,201	0.000000	0.000000	448,162	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENT	0	231,802	0.000000	0.000000	12,923	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	2,560,462	0.000000	0.000000	714,343	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	2,052,364	0.000000	0.000000	0	88.00	
88.01 RURAL HEALTH CLINIC II	0	2,484,211	0.000000	0.000000	0	88.01	
91.00 EMERGENCY	0	8,518,993	0.000000	0.000000	2,294	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	393,156	0.000000	0.000000	0	92.00	
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES						95.00	
200.00 Total (lines 50-199)	0	50,022,848			3,467,254	200.00	

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XVIII			Hospital		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		23.00	24.00			
50.00	OPERATING ROOM	0	0			50.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	LABORATORY	0	0			60.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
88.01	RURAL HEALTH CLINIC II	0	0			88.01
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part V
Date/Time Prepared:
1/26/2012 5:58 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)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	3.00	4.00	
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.412995	0	934,809	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.121734	0	3,551,477	0	54.00
60.00	LABORATORY	0.146774	0	5,441,891	0	60.00
65.00	RESPIRATORY THERAPY	0.174459	0	384,288	0	65.00
66.00	PHYSICAL THERAPY	0.311408	0	568,303	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142	0	215,772	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.262375	0	64,832	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.304870	0	573,676	1,030	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
88.01	RURAL HEALTH CLINIC II	0.000000				88.01
91.00	EMERGENCY	0.356373	0	2,359,709	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.927319	0	232,076	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.697171		0		95.00
200.00	Subtotal (see instructions)		0	14,326,833	1,030	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	14,326,833	1,030	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part V
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Title XVIII			Hospital	Cost
	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	386,071	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	432,336	0		54.00
60.00 LABORATORY	0	798,728	0		60.00
65.00 RESPIRATORY THERAPY	0	67,043	0		65.00
66.00 PHYSICAL THERAPY	0	176,974	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,243	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	17,010	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	174,897	314		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
88.01 RURAL HEALTH CLINIC II	0	0	0		88.01
91.00 EMERGENCY	0	840,937	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	215,208	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	3,150,447	314		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,150,447	314		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 5:58 pm
	Component CCN: 152307		

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.412995	0	0	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.121734	0	0	0	54.00
60.00	LABORATORY	0.146774	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0.174459	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.311408	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.262375	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.304870	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
88.01	RURAL HEALTH CLINIC II	0.000000				88.01
91.00	EMERGENCY	0.356373	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.927319	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.697171		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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part V
Date/Time Prepared:
1/26/2012 5:58 pm

Component CCN:15z307

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
88.01 RURAL HEALTH CLINIC II	0	0	0		88.01
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part I
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital		PPS
				Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	218,211	36,942	181,269	2,846	63.69	30.00
200.00 Total (lines 30-199)	218,211		181,269	2,846		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151307		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 5:58 pm	
		Title XIX		Hospital		PPS	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6:00	7:00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	183	11,655			30.00	
200.00	Total (lines 30-199)	183	11,655			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part II
Date/Time Prepared:
1/26/2012 5:58 pm

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)	Title XIX		
				Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	144,185	3,306,527	0.043606	49,922	2,177	50.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	109,641	12,395,771	0.008845	54,853	485	54.00
60.00 LABORATORY	71,263	13,354,085	0.005336	98,380	525	60.00
65.00 RESPIRATORY THERAPY	30,024	1,338,529	0.022431	81,119	1,820	65.00
66.00 PHYSICAL THERAPY	66,506	1,963,747	0.033867	7,109	241	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,613	1,423,201	0.013781	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	561	231,802	0.002420	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	20,944	2,560,462	0.008180	92,957	760	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	149,085	2,052,364	0.072641	0	0	88.00
88.01 RURAL HEALTH CLINIC II	212,955	2,484,211	0.085723	0	0	88.01
91.00 EMERGENCY	107,581	8,518,993	0.012628	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	32,893	393,156	0.083664	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	965,251	50,022,848		384,340	6,008	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151307		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 5:58 pm	
		Title XIX		Hospital		PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	0	0	0	0	0 30.00		
200.00 Total (lines 30-199)	0	0	0	0	0 200.00		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151307		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 5:58 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 - col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,846	0.00	183	0	0	30.00
200.00	Total (lines 30-199)	2,846		183	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151307		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 5:58 pm	
				Title XIX		Hospital	
Cost Center Description		PSA Adj. Allied Health Cost 12.00	PSA Adj. All Other Medical Education Cost 13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0			30.00	
200.00	Total (Lines 30-199)	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital		PPS
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. G, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	3,306,527	0.000000	0.000000	49,922	50.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	12,395,771	0.000000	0.000000	54,853	54.00
60.00 LABORATORY	0	13,354,085	0.000000	0.000000	98,380	60.00
65.00 RESPIRATORY THERAPY	0	1,338,529	0.000000	0.000000	81,119	65.00
66.00 PHYSICAL THERAPY	0	1,963,747	0.000000	0.000000	7,109	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,423,201	0.000000	0.000000	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	231,802	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,560,462	0.000000	0.000000	92,957	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,052,364	0.000000	0.000000	0	88.00
88.01 RURAL HEALTH CLINIC II	0	2,484,211	0.000000	0.000000	0	88.01
91.00 EMERGENCY	0	8,518,993	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	393,156	0.000000	0.000000	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	50,022,848			384,340	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital		PPS	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES							95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	LABORATORY	0	0			60.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
88.01	RURAL HEALTH CLINIC II	0	0			88.01
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
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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)		3,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,846	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,846	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		282	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)		298	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		36	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)		36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,785	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)		282	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)		298	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		152.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		152.53	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,922,536	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)		5,491	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		5,491	25.00
26.00	Total swing-bed cost (see instructions)		503,889	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,418,647	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,033,587	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,033,587	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.797289	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)		1,065.91	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,418,647	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)		849.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,516,964	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,516,964	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total Inpatient	Total Inpatient Cost	Average Per Day (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	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)					707,263	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,224,227	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)					239,655	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					253,252	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					492,907	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)					429	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					849.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					364,581	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
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Cost Center Description	Cost	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Routine Cost (from line 27)	column 1 - column 2	Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 5:58 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,498 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,846 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,846 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)			580 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)			72 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			183 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,922,536 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)			494,769 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,427,767 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			3,033,587 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,033,587 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.800296 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)			1,065.91 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,427,767 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)			853.05 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			156,108 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)			156,108 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
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		Title XIX		Hospital	PPS		
Cost Center	Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	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							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					86,441	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					242,549	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)					11,655	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,008	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					17,663	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					224,886	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING-BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					429	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					853.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					365,958	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		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	218,211	2,427,767	0.089881	365,958	32,893	90.00
91.00 Nursing School cost	0	2,427,767	0.000000	365,958	0	91.00
92.00 Allied health cost	0	2,427,767	0.000000	365,958	0	92.00
93.00 All other Medical Education	0	2,427,767	0.000000	365,958	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3

Date/Time Prepared:
1/26/2012 5:58 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 ADULTS & PEDIATRICS		1,605,645	30.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.412995	118,165	50.00
53.00 ANESTHESIOLOGY	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.121734	578,683	54.00
60.00 LABORATORY	0.146774	984,502	60.00
65.00 RESPIRATORY THERAPY	0.174459	390,875	65.00
66.00 PHYSICAL THERAPY	0.311408	217,307	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142	448,162	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.262375	12,923	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.304870	714,343	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0.000000		88.00
88.01 RURAL HEALTH CLINIC II	0.000000		88.01
91.00 EMERGENCY	0.356373	2,294	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.927319	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES			95.00
200.00 Total (sum of lines 50-94 and 96-98)		3,467,254	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00 Net Charges (line 200 minus line 201)		3,467,254	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151307
Component CCN: 152307

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-3
Date/Time Prepared:
1/26/2012 5:58 pm

Cost-Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.412995	8,734	3,607	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.121734	68,465	8,335	54.00
60.00	LABORATORY	0.146774	134,794	19,784	60.00
65.00	RESPIRATORY THERAPY	0.174459	90,390	15,769	65.00
66.00	PHYSICAL THERAPY	0.311408	237,610	73,994	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142	99,956	19,106	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.262375	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.304870	170,250	51,904	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	EMERGENCY	0.356373	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.927319	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		810,199	192,499	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		810,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 5:58 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	PPS
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		175,430		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.412995	49,922	20,618	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.121734	54,853	6,677	54.00
60.00	LABORATORY	0.146774	98,380	14,440	60.00
65.00	RESPIRATORY THERAPY	0.174459	81,119	14,152	65.00
66.00	PHYSICAL THERAPY	0.311408	7,109	2,214	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.191142	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.262375	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.304870	92,957	28,340	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.951104	0	0	88.00
88.01	RURAL HEALTH CLINIC II	1.071643	0	0	88.01
91.00	EMERGENCY	0.356373	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.930821	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		384,340	86,441	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)		384,340		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet E
Part B
Date/Time Prepared:
1/26/2012 5:58 pm

		Title XVIII	Hospital	Cost		
					1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES						
1.00	Medical and other services (see instructions)			3,150,761	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00	
3.00	PPS payments			0	3.00	
4.00	Outlier payment (see instructions)			0	4.00	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00	
6.00	Line 2 times line 5			0	6.00	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00	
8.00	Transitional corridor payment (see instructions)			0	8.00	
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0	9.00	
10.00	Organ acquisitions			0	10.00	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,150,761	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES						
Reasonable charges						
12.00	Ancillary service charges			0	12.00	
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0	13.00	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00	
customary charges						
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0	16.00	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00	
18.00	Total customary charges (see instructions)			0	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,182,269	21.00	
22.00	Interns and residents (see instructions)			0	22.00	
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0	23.00	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
25.00	Deductibles and coinsurance (for CAH, see instructions)			39,184	25.00	
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			1,784,217	26.00	
27.00	Subtotal [(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23] (for CAH, see instructions)			1,358,868	27.00	
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0	28.00	
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0	29.00	
30.00	Subtotal (sum of lines 27 through 29)			1,358,868	30.00	
31.00	Primary payer payments			394	31.00	
32.00	Subtotal (line 30 minus line 31)			1,358,474	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)			312,199	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)			312,199	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			278,441	36.00	
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,670,673	37.00	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99	
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,670,673	40.00	
41.00	Interim payments			1,525,046	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)			145,627	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet E
Part B
Date/Time Prepared:
1/26/2012 5:58 pm

	Title XVIII	Hospital	Cost
WORKSHEET OVERRIDE VALUES			overrides
			1.00
112.00	override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151307		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 5:58 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		1,642,437		1,655,002	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	02/10/2011	94,387		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	02/10/2011	0		114,558	3.50	
3.51		06/07/2011	32,569		15,398	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)		61,818		-129,956	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		1,704,255		1,525,046	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		179,123		145,627	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,883,378		1,670,673	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: 151307
Component CCN: 15z307

Period:
From 07/01/2010
To 06/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
1/26/2012 5:58 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		599,081		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	02/10/2011	36,855		0	3.01
3.02		06/07/2011	81,000		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		117,855		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)		716,936		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		34,130		0	6.02
7.00	Total Medicare program liability (see instructions)		682,806		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor		0			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151307
Component CCN: 15z307

Period:
From 07/01/2010
To 06/30/2011

Worksheet E-2
Date/Time Prepared:
1/26/2012 5:58 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)	497,836	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)	194,424	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	580	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)	692,260	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	692,260	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)	692,260	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,454	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)	682,806	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	682,806	0	19.00
20.00	Interim payments	716,936	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)	-34,130	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: 151307

Period:
From 07/01/2010
To 06/30/2011Worksheet E-3
Part V
Date/Time Prepared:
1/26/2012 5:58 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)					
1.00	Inpatient services			2,224,227	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,224,227	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)			2,246,469	6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,246,469	19.00
20.00	Deductibles (exclude professional component)			398,384	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)			1,848,085	22.00
23.00	Coinsurance			1,100	23.00
24.00	Subtotal (line 22 minus line 23)			1,846,985	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			36,393	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			36,393	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			26,513	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))			1,883,378	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)			1,883,378	30.00
31.00	Interim payments			1,704,255	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)			179,123	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet E-3
Part VII
Date/Time Prepared:
1/26/2012 5:58 pm

Title XIX

Hospital

PPS

1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES

1.00	Inpatient hospital/SNF/NF services	0	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	7.00

COMPUTATION OF LESSER OF COST OR CHARGES

Reasonable Charges

8.00	Routine service charges	0	8.00
9.00	Ancillary service charges	384,340	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	384,340	12.00

CUSTOMARY CHRGES

13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	384,340	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)	384,340	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (line 7)	0	21.00

PROSPECTIVE PAYMENT AMOUNT

22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26, plus line 3 minus lines 5 and 6)	0	27.00
28.00	Customary charges (title XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX (see instructions)	0	29.00

COMPUTATION OF REIMBURSEMENT SETTLEMENT

30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)	0	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	40.00
41.00	Interim payments	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet G

Date/Time Prepared:
1/26/2012 5:58 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	3,275,669	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	6,925,508	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-4,430,928	0	0	0	6.00
7.00 Inventory	229,044	0	0	0	7.00
8.00 Prepaid expenses	39,038	0	0	0	8.00
9.00 Other current assets	257,935	0	0	0	9.00
10.00 Due from other funds	234,785	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	6,531,051	0	0	0	11.00
FIXED ASSETS					
12.00 Land	280,231	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	12,163,717	0	0	0	15.00
16.00 Accumulated depreciation	-6,762,257	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	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	0	0	0	0	23.00
24.00 Accumulated depreciation	0	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)	5,681,691	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	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	23,037,414	366,317	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	23,037,414	366,317	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	35,250,156	366,317	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	256,628	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,433,907	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	30,328	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	499,014	0	0	0	43.00
44.00 Other current liabilities	498,785	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	2,718,662	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	4,185,380	0	0	0	48.00
49.00 Other long term liabilities	34,760	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	4,220,140	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	6,938,802	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	28,311,354	0	0	0	52.00
53.00 Specific purpose fund	0	366,317	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	28,311,354	366,317	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	35,250,156	366,317	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
1/26/2012 5:58 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		22,134,502		355,291	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		5,362,277			2.00
3.00 Total (sum of line 1 and line 2)		27,496,779		355,291	3.00
4.00 DEFERRED PENSION COSTS	814,575				4.00
5.00 GRANT REVENUE	0		17,111		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)		814,575		17,111	10.00
11.00 Subtotal (line 3 plus line 10)		28,311,354		372,402	11.00
12.00 NET ASSETS RELEASED	0		6,085		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		6,085	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		28,311,354		366,317	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
1/26/2012 5:58 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 DEFERRED PENSION COSTS	0			0		4.00
5.00 GRANT REVENUE	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 NET ASSETS RELEASED	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: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
1/26/2012 5:58 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	3,033,587		3,033,587	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY				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)	3,033,587		3,033,587	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)	3,033,587		3,033,587	17.00
18.00 Ancillary services	6,376,689	41,181,429	47,558,118	18.00
19.00 Outpatient services	0	0	0	19.00
20.00 RURAL HEALTH CLINIC	250,202	2,052,364	2,302,566	20.00
20.01 RURAL HEALTH CLINIC II	334,990	2,484,211	2,819,201	20.01
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES	160,927	1,361,881	1,522,808	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)	10,156,395	47,079,885	57,236,280	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		19,405,275		29.00
30.00 BAD DEBT	3,922,695			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)		3,922,695		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)		23,327,970		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151307

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-3

Date/Time Prepared:
1/26/2012 5:58 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	57,236,280	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,759,165	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,477,115	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	23,327,970	4.00
5.00	Net income from service to patients (line 3 minus line 4)	149,145	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,312,710	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	3,690	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	AMBULANCE SUBSIDY	305,701	24.00
24.01	CREDENTIALING	4,550	24.01
24.02	RENTAL INCOME	16,150	24.02
24.03	MISCELLANEOUS	32,060	24.03
24.04	ENT CLINIC	1,200	24.04
24.05	INTEREST	289	24.05
24.06	PHARMACY	2,850	24.06
24.07	MEDICAL DIRECTOR FEES	10,200	24.07
24.08	AP REFUNDS	7,800	24.08
24.09	PATIENT MONEY	551	24.09
24.10	ORTHO CLINIC	1,465,204	24.10
24.12	STALE DATED CHECKS	37,051	24.12
24.13	CLOSED BANK ACCOUNT	6,514	24.13
24.14	FOOD SERVICES	13,154	24.14
24.15	NET ASSETS RELEASED	6,085	24.15
24.16	A&G INTEREST	855,664	24.16
24.17	PHYSICAL THERAPY	22,925	24.17
24.18	NORTH CLINIC	95,270	24.18
24.19	SOUTH CLINIC	13,514	24.19
25.00	Total other income (sum of lines 6-24)	5,213,132	25.00
26.00	Total (line 5 plus line 25)	5,362,277	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,362,277	29.00

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

Provider CCN: 151307
Component CCN: 153993

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-1
Date/Time Prepared:
1/26/2012 5:58 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	453,614	0	453,614	-65,308	388,306	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	76,309	0	76,309	0	76,309	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	175,314	0	175,314	0	175,314	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	137,550	0	137,550	0	137,550	9.00
10.00	Subtotal (sum of lines 1-9)	842,787	0	842,787	-65,308	777,479	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	13,138	13,138	0	13,138	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	135,838	135,838	0	135,838	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	148,976	148,976	0	148,976	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	842,787	148,976	991,763	-65,308	926,455	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	842,787	148,976	991,763	-65,308	926,455	32.00

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

Provider CCN: 151307
Component CCN: 153993

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-1
Date/Time Prepared:
1/26/2012 5:58 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	-17	388,289	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	76,309	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	175,314	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	0	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	137,550	9.00
10.00 Subtotal (sum of lines 1-9)	-17	777,462	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	0	13.00
14.00 Subtotal (sum of lines 11-13)	0	0	14.00
15.00 Medical Supplies	0	13,138	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	135,838	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15-20)	0	148,976	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-17	926,438	22.00
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	0	0	29.00
30.00 Administrative Costs	0	0	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-17	926,438	32.00

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

Provider CCN: 151307
Component CCN: 153994

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-1
Date/Time Prepared:
1/26/2012 5:58 pm

Title XVIII

Rural Health
Clinic (RHC) II

Cost

	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	385,543	0	385,543	0	385,543	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	246,206	0	246,206	-87,005	159,201	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	210,507	0	210,507	0	210,507	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	295,485	0	295,485	0	295,485	9.00
10.00	Subtotal (sum of lines 1-9)	1,137,741	0	1,137,741	-87,005	1,050,736	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	17,580	17,580	0	17,580	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	173,759	173,759	0	173,759	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	191,339	191,339	0	191,339	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,137,741	191,339	1,329,080	-87,005	1,242,075	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,137,741	191,339	1,329,080	-87,005	1,242,075	32.00

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

Provider CCN: 151307
Component CCN: 153994

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-1
Date/Time Prepared:
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Title XVIII

Rural Health
Clinic (RHC) II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	385,543	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	159,201	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	210,507	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	295,485	9.00
10.00	Subtotal (sum of lines 1-9)	0	1,050,736	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	17,580	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	173,759	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	191,339	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,242,075	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,242,075	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151307
Component CCN: 153993

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-2
Date/Time Prepared:
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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	2.83	10,043	4,200	11,886	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	4,238	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	3.83	14,281		13,986	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.83	14,281			8.00
9.00	Physician Services Under Agreements		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)	926,438	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)	926,438	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,025,574	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,025,574	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	1,025,574	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,025,574	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,952,012	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151307
Component CCN: 153994

Period:
From 07/01/2010
To 06/30/2011

Worksheet M-2
Date/Time Prepared:
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Title XVIII

Rural Health
Clinic (RHC) II

Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.69	7,444	4,200	7,098	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	3.00	9,709	2,100	6,300	3.00
4.00	Subtotal (sum of lines 1-3)	4.69	17,153		13,398	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)	4.69	17,153		17,153	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)				1,242,075	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)				1,242,075	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)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,420,112	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,420,112	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				1,420,112	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,420,112	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				2,662,187	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151307 Component CCN: 153993	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/26/2012 5:58 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)		1,952,012	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,952,012	3.00
4.00	Total Visits (from worksheet M-2, column 5, line 8)		14,281	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)		14,281	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		136.69	7.00
Calculation of Limit (1)				
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	136.69	136.69	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,599	1,649	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	218,567	225,402	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) *	218,567	225,402	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		130,202	16.04
16.05	Total program cost (see instructions)	174,854	130,202	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		62,650	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)		305,056	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		305,056	22.00
23.00	Reimbursable bad debts (see instructions)		218	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		305,274	26.00
27.00	Interim payments		267,960	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)		37,314	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151307	Period: From 07/01/2010	Worksheet M-3
	Component CCN: 153994	To 06/30/2011	Date/Time Prepared: 1/26/2012 5:58 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)		2,662,187	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,662,187	3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)		17,153	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)		17,153	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		155.20	7.00
Calculation of Limit (1)				
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	155.20	155.20	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,454	2,458	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	380,861	381,482	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) *	380,861	381,482	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		255,769	16.04
16.05	Total program cost (see instructions)	304,689	255,769	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		61,771	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)		560,458	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		560,458	22.00
23.00	Reimbursable bad debts (see instructions)		354	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		560,812	26.00
27.00	Interim payments		497,070	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)		63,742	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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151307 Component CCN:153993	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/26/2012 5:58 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	250,962	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		02/10/2011	16,998	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)		16,998	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		267,960	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	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		37,314	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		305,274	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151307	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5
	Component CCN: 153994		Date/Time Prepared: 1/26/2012 5:58 pm

Title XVIII	Rural Health Clinic (RHC) II	Cost
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		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		461,518	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		02/10/2011	35,552	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)		35,552	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		497,070	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		63,742	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		560,812	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

**St. Vincent Williamsport
Notes for Meeting with CFO
6/30/11**

Open Items

1. Pension (Gary Marker)
2. Bad Debt (Gary Marker)
3. S-10 (Jennifer Berry)

Prior Year Statistics/ Estimates

None

Comments

1. Medical records time study
 - a. Significant amount going to NRCC
 - b. Nothing getting allocated to lab
2. Expenses (salary) but no revenue for New Horizon Outpatient (cc 7516)

General Review of Cost Report Workpapers

1. Mapping
 - a. Expenses
 - i. Overhead
 - ii. Reimbursable: consistent with revenue and statistics groupings
 - iii. NRCC (be sure not to offset revenue)
 - b. Gross Revenue
 - c. PS&R
2. Statistics
3. Reclassifications
4. Adjustments

Contractual Model

See contractual model analysis