

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: 140137	Period: From 01/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/6/2013 2:18 pm

PART I - COST REPORT STATUS		
Provider use only	1. <input checked="" 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: _____ Time: _____
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 certification 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 GREENVILLE REGIONAL HOSPITAL (140137) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	10,414	31,608	838,671	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	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	-4,638	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	126,488	0	0	10.00
10.01 RURAL HEALTH CLINIC II II	0	0	0	0	0	10.01
10.02 RURAL HEALTH CLINIC III III	0	0	0	0	0	10.02
10.03 RURAL HEALTH CLINIC IV IV	0	0	0	0	0	10.03
10.04 RURAL HEALTH CLINIC V V	0	0	0	0	0	10.04
10.05 RURAL HEALTH CLINIC VI VI	0	0	0	0	0	10.05
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	5,776	158,096	838,671	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: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/6/2013 2:18 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				1.00	
1.00	Street: 200 HEALTHCARE DRIVE	PO Box:									1.00
2.00	City: GREENVILLE	State: IL	Zip Code: 62246-1156		County: BOND						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	GREENVILLE REGIONAL HOSPITAL	140137	41180	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	GREENVILLE I/P PSYCH UNIT	14S137	41180	4	01/01/2005	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENVILLE REGIONAL HOSP- SWING BED	14U137	41180		10/03/2001	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAIR OAKS	146022	41180		05/20/2002	N	P	N	9.00
10.00	Hospital-Based NF	FAIR OAKS	146022	41180		05/20/2002	N		O	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	GREENVILLE FAMILY WELLNESS	143491	41180		07/24/2007	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	GREENVILLE FAMILY WELLNESS	143498	41180		07/22/2007	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	GREENVILLE MEDICAL ASSOCIATES	148512	41180		12/01/2010	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	GREENVILLE MEDICAL ASSOCIATES	148513	41180		12/01/2010	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519	41180		09/01/2011	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MCCRACKEN DAWDY HALL FAMILY PRACTICE	148520	41180		09/01/2011	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	635	0	0	0	484	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
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
		Y/N	Y/N			
		1.00	2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	Y	Y			39.00
		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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	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, if line 63 is yes, or your facility trained residents in the base year period, 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	
		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, if line 63 is yes, or your facility trained residents in the base year period, 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)					65.00
			0.00	0.00	0.000000	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	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	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	

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		V 1.00	XIX 2.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00	0.00	97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			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.				109.00	
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	547,817	35,480	5,000,000	118.01	
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 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 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			140.00

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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:	PO Box:					142.00	
143.00	City:	State:		Zip Code:			143.00	
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N	145.00
							1.00	
							2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
161.10	CORF		N	N	N		161.10	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					41180	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.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/6/2013 2:18 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/25/2013	Y	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		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		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		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOSH		WI LKS	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4309		JOSHUA.WI LKS@CLIFTONLARSONALLEN.COM	43.00

		Part B	
		Date	
		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)		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)	03/25/2013	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.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/6/2013 2:18 pm
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	32	11,712	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		32	11,712	0.00	0	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	43.00				0	13.00
14.00 Total (see instructions)		32	11,712	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	10	3,660		0	19.00
20.00 NURSING FACILITY	45.00	98	35,868		0	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.05 RURAL HEALTH CLINIC VI	88.05				0	26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		150				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,166	410	2,176			1.00
2.00 HMO	21	484				2.00
3.00 HMO IPF Subprovider	4	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	941	0	1,058			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	61			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,107	410	3,295			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		225	383			13.00
14.00 Total (see instructions)	2,107	635	3,678	0.00	242.77	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,870	0	1,925	0.00	14.32	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	1,429	0	1,436	0.00	3.19	19.00
20.00 NURSING FACILITY		13,859	22,453	0.00	49.89	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	9,900	10,938	39,525	0.00	44.03	26.00
26.01 RURAL HEALTH CLINIC II	0	0	0	0.00	0.00	26.01
26.02 RURAL HEALTH CLINIC III	0	0	0	0.00	0.00	26.02
26.03 RURAL HEALTH CLINIC IV	0	0	0	0.00	0.00	26.03
26.04 RURAL HEALTH CLINIC V	0	0	0	0.00	0.00	26.04
26.05 RURAL HEALTH CLINIC VI	0	0	0	0.00	0.00	26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	354.20	27.00
28.00 Observation Bed Days		0	437			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		57	99			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	363	203	826	1.00
2.00 HMO			9			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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	0	363	203	826	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	191	0	210	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					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
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
26.05 RURAL HEALTH CLINIC VI	0.00					26.05
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part II Date/Time Prepared: 5/6/2013 2:18 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	17,963,854	0	17,963,854	736,756.00	24.38
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	409,023	409,023	4,550.00	89.90
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		2,682,390	0	2,682,390	15,378.00	174.43
6.00	Non-physician-Part B		671,020	0	671,020	13,022.25	51.53
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	1,785	86,967	88,752	6,625.00	13.40
10.00	Excluded area salaries (see instructions)		3,411,504	-86,967	3,324,537	180,225.00	18.45
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,387,546	0	1,387,546	23,296.00	59.56
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		2,909,673	0	2,909,673		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		1,001,557	0	1,001,557		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		25,286	0	25,286		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		85,460	0	85,460		
24.00	Wage-related costs (RHC/FOHC)		72,368	0	72,368		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	153,575	0	153,575	6,104.00	25.16
27.00	Administrative & General	5.00	2,178,353	0	2,178,353	66,311.00	32.85
28.00	Administrative & General under contract (see inst.)		126,682	0	126,682	677.05	187.11
29.00	Maintenance & Repairs	6.00	290,472	0	290,472	13,342.00	21.77
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	136,701	0	136,701	12,846.00	10.64
32.00	Housekeeping	9.00	371,709	0	371,709	33,944.00	10.95
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	497,913	-146,961	350,952	44,798.00	7.83
35.00	Dietary under contract (see instructions)		12,445	0	12,445	345.00	36.07
36.00	Cafeteria	11.00	0	146,961	146,961	13,224.37	11.11
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	528,971	0	528,971	39,521.00	13.38
39.00	Central Services and Supply	14.00	98,920	0	98,920	5,820.00	17.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	369,802	0	369,802	21,914.00	16.88

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hou rs Rel ated to Sal ari es i n col . 4	Average Hou rly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part III
Date/Time Prepared:
5/6/2013 2:18 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	14,749,571	-409,023	14,340,548	704,827.80	20.35	1.00
2.00	Excluded area salaries (see instructions)	3,413,289	0	3,413,289	186,850.00	18.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,336,282	-409,023	10,927,259	517,977.80	21.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,387,546	0	1,387,546	23,296.00	59.56	4.00
5.00	Subtotal wage-related costs (see inst.)	2,909,673	0	2,909,673	0.00	26.63	5.00
6.00	Total (sum of lines 3 thru 5)	15,633,501	-409,023	15,224,478	541,273.80	28.13	6.00
7.00	Total overhead cost (see instructions)	4,765,543	0	4,765,543	258,846.42	18.41	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/6/2013 2:18 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			181,267 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2,266,905 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			75,029 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			57,663 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			253,253 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			1,181,873 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			78,353 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			4,094,343 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part V
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-7

Date/Time Prepared:
5/6/2013 2:18 pm

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	50	0	50	4.00
5.00	RVX	0	7	7	5.00
6.00	RVL	31	18	49	6.00
7.00	RHX	14	0	14	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	136	55	191	12.00
13.00	RUB	84	32	116	13.00
14.00	RUA	278	237	515	14.00
15.00	RVC	61	23	84	15.00
16.00	RVB	119	107	226	16.00
17.00	RVA	382	369	751	17.00
18.00	RHC	83	1	84	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	8	0	8	20.00
21.00	RMC	31	5	36	21.00
22.00	RMB	6	8	14	22.00
23.00	RMA	61	2	63	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	20	13	33	28.00
29.00	HE2	0	2	2	29.00
30.00	HE1	0	7	7	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	3	3	6	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	5	5	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	8	0	8	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	40	3	43	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	6	6	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	9	6	15	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	7	7	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	10	10	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	5	14	19	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-7

Date/Time Prepared:
5/6/2013 2:18 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	1	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,429	941	2,370	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		41180	41180	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		188,010			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/6/2013 2:18 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification Street		150 HEALTHCARE DRIVE	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		GREENVILLE IL62246	2.00
				1.00
3.00	FOHCs 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 FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00
		Sunday	Monday	Tuesday
		from to	from to	from
		1.00 2.00	3.00 4.00	5.00
11.00	Facility hours of operations (1) Clinic		07:00 19:00	07:00 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. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y	6 13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number		GREENVILLE FAMILY WELLNESS	143491 14.00
14.01			GREENVILLE FAMILY WELLNESS	143498 14.01
14.02			GREENVILLE MEDICAL ASSOCIATES	148512 14.02
14.03			GREENVILLE MEDICAL ASSOCIATES	148513 14.03
14.04			MCCRACKEN DAWDY HALL FAMILY PRACTICE	148519 14.04
14.05			MCCRACKEN DAWDY HALL FAMILY PRACTICE	148520 14.05

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140137	Period: From 01/01/2012	Worksheet S-8
	Component CCN: 143491	To 12/31/2012	Date/Time Prepared: 5/6/2013 2:18 pm
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/6/2013 2:18 pm	
			Rural Health Clinic (RHC) I	Cost	
		County			
		4.00			
2.00	City, State, Zip Code, County	BOND			2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from to
		6.00	7.00	8.00	9.00 10.00
11.00	Facility hours of operations (1) Clinic	17:00	07:00	17:00	07:00 17:00
					11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/6/2013 2:18 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday			
	from	to	from	to		
	11.00	07:00	17:00	08:00		

Facility hours of operations (1)

Clinic

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-10

Date/Time Prepared:
5/6/2013 2:18 pm

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.436878	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,518,831	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				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			996,765	5.00
6.00	Medicaid charges			12,424,484	6.00
7.00	Medicaid cost (line 1 times line 6)			5,427,984	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)			2,912,388	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,912,388	19.00
				1.00	
				2.00	
				3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,281,891	429,068	1,710,959	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	560,030	187,450	747,480	21.00
22.00	Partial payment by patients approved for charity care	1,081	6,026	7,107	22.00
23.00	Cost of charity care (line 21 minus line 22)	558,949	181,424	740,373	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,341,291	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			207,414	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			2,133,877	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			932,244	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,672,617	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,585,005	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,912,547	1,912,547	-242,394	1,670,153	1.00
2.00	00200		752,264	752,264	797,932	1,550,196	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	153,575	4,485,730	4,639,305	0	4,639,305	4.00
5.00	00500	2,178,353	2,491,394	4,669,747	-62,237	4,607,510	5.00
6.00	00600	290,472	940,381	1,230,853	0	1,230,853	6.00
8.00	00800	136,701	34,551	171,252	0	171,252	8.00
9.00	00900	371,709	74,837	446,546	0	446,546	9.00
10.00	01000	497,913	503,752	1,001,665	-306,730	694,935	10.00
11.00	01100	0	0	0	306,730	306,730	11.00
13.00	01300	528,971	48,000	576,971	0	576,971	13.00
14.00	01400	98,920	14,697	113,617	0	113,617	14.00
16.00	01600	369,802	53,837	423,639	0	423,639	16.00
19.00	01900	0	0	0	496,465	496,465	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,776,084	642,001	2,418,085	-376,112	2,041,973	30.00
40.00	04000	579,216	133,697	712,913	0	712,913	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	298,873	298,873	43.00
44.00	04400	1,785	0	1,785	101,211	102,996	44.00
45.00	04500	1,476,466	236,961	1,713,427	-101,211	1,612,216	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	596,187	204,599	800,786	0	800,786	50.00
52.00	05200	0	0	0	77,239	77,239	52.00
53.00	05300	414,523	113,796	528,319	-496,465	31,854	53.00
54.00	05400	560,889	645,736	1,206,625	0	1,206,625	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	586,507	922,835	1,509,342	0	1,509,342	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	245,340	18,773	264,113	-84,947	179,166	65.00
66.00	06600	0	877,747	877,747	-317,848	559,899	66.00
67.00	06700	0	-89	-89	219,664	219,575	67.00
68.00	06800	0	0	0	98,184	98,184	68.00
69.00	06900	0	52,751	52,751	84,947	137,698	69.00
71.00	07100	0	414,282	414,282	0	414,282	71.00
72.00	07200	0	39,980	39,980	0	39,980	72.00
73.00	07300	395,852	1,236,505	1,632,357	0	1,632,357	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	134,435	125,328	259,763	0	259,763	75.01
76.97	07697	10,340	915	11,255	0	11,255	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	4,565,649	582,504	5,148,153	0	5,148,153	88.00
88.01	08801	0	0	0	0	0	88.01
88.02	08802	0	0	0	0	0	88.02
88.03	08803	0	0	0	0	0	88.03
88.04	08804	0	0	0	0	0	88.04
88.05	08805	0	0	0	0	0	88.05
90.00	09000	95,145	28,980	124,125	0	124,125	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	543,198	1,441,715	1,984,913	0	1,984,913	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	528,685	86,643	615,328	0	615,328	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	493,301	493,301	-493,301	0	113.00
118.00		17,136,717	19,610,950	36,747,667	0	36,747,667	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	715,279	60,093	775,372	0	775,372	192.00
193.00	19300	47,394	199,279	246,673	0	246,673	193.00
194.00	07950	64,464	345,215	409,679	0	409,679	194.00
200.00		17,963,854	20,215,537	38,179,391	0	38,179,391	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-327,582	1,342,571	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-9,523	1,540,673	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-1,106,160	3,533,145	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-304,363	4,303,147	5.00
6.00	00600	MAINTENANCE & REPAIRS	-9,485	1,221,368	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	171,252	8.00
9.00	00900	HOUSEKEEPING	-48	446,498	9.00
10.00	01000	DIETARY	-50,846	644,089	10.00
11.00	01100	CAFETERIA	-133,272	173,458	11.00
13.00	01300	NURSING ADMINISTRATION	-9,007	567,964	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	113,617	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,659	405,980	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-496,465	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-636,374	1,405,599	30.00
40.00	04000	SUBPROVIDER - I PF	-91,521	621,392	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	298,873	43.00
44.00	04400	SKILLED NURSING FACILITY	0	102,996	44.00
45.00	04500	NURSING FACILITY	0	1,612,216	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	800,786	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	77,239	52.00
53.00	05300	ANESTHESIOLOGY	0	31,854	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-21,205	1,185,420	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-12,256	1,497,086	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-1,485	177,681	65.00
66.00	06600	PHYSICAL THERAPY	0	559,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	219,575	67.00
68.00	06800	SPEECH PATHOLOGY	0	98,184	68.00
69.00	06900	ELECTROCARDIOLOGY	-46,821	90,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-416	413,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	39,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-230,524	1,401,833	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	-24,000	235,763	75.01
76.97	07697	CARDIAC REHABILITATION	0	11,255	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-272,495	4,875,658	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	88.05
90.00	09000	CLINIC	-23,450	100,675	90.00
90.01	09001	WELLNESS LINK	0	0	90.01
91.00	09100	EMERGENCY	-1,388,006	596,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-24,736	590,592	95.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,237,699	31,509,968	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	775,372	192.00
193.00	19300	NONPAID WORKERS	0	246,673	193.00
194.00	07950	EMERALD POINT	0	409,679	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-5,237,699	32,941,692	200.00

RECLASSIFICATIONS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/6/2013 2:18 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	409,023	87,442	1.00
	TOTALS		409,023	87,442	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	146,961	159,769	1.00
	TOTALS		146,961	159,769	
C - DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	754,972	1.00
	TOTALS		0	754,972	
D - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	84,947	0	1.00
	TOTALS		84,947	0	
E - OB EXPENSE					
1.00	NURSERY	43.00	254,424	44,449	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	65,752	11,487	2.00
	TOTALS		320,176	55,936	
F - CONTRACT THERAPY EXPENSE					
1.00	OCCUPATIONAL THERAPY	67.00	0	219,664	1.00
2.00	SPEECH PATHOLOGY	68.00	0	98,184	2.00
	TOTALS		0	317,848	
G - PROPERTY INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	62,237	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	62,237	
H - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	464,925	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	28,376	2.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	493,301	
I - NF TO SNF					
1.00	SKILLED NURSING FACILITY	44.00	86,967	14,244	1.00
	TOTALS		86,967	14,244	
500.00	Grand Total: Increases		1,048,074	1,945,749	500.00

RECLASSIFICATIONS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/6/2013 2:18 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	409,023	87,442	0		1.00
	TOTALS		409,023	87,442			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	146,961	159,769	0		1.00
	TOTALS		146,961	159,769			
C - DEPRECIATION EXPENSE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	754,972	10		1.00
	TOTALS		0	754,972			
D - EKG SALARIES							
1.00	RESPIRATORY THERAPY	65.00	84,947	0	0		1.00
	TOTALS		84,947	0			
E - OB EXPENSE							
1.00	ADULTS & PEDIATRICS	30.00	320,176	55,936	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		320,176	55,936			
F - CONTRACT THERAPY EXPENSE							
1.00	PHYSICAL THERAPY	66.00	0	317,848	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	317,848			
G - PROPERTY INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,237	9		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	62,237			
H - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	493,301	9		1.00
2.00		0.00	0	0	10		2.00
15.00		0.00	0	0	9		15.00
16.00		0.00	0	0	10		16.00
	TOTALS		0	493,301			
I - NF TO SNF							
1.00	NURSING FACILITY	45.00	86,967	14,244	0		1.00
	TOTALS		86,967	14,244			
500.00	Grand Total: Decreases		1,048,074	1,945,749			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/6/2013 2:18 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	1,212,192	6,200	0	6,200	2.00
3.00	Buildings and Fixtures	30,707,335	146,458	0	146,458	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	9,560,209	640,252	0	640,252	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,479,736	792,910	0	792,910	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,479,736	792,910	0	792,910	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	1,912,547	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	752,264	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,664,811	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	32,058,706	0	32,058,706	0.765674	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	9,811,205	0	9,811,205	0.234326	2.00
3.00	Total (sum of lines 1-2)	41,869,911	0	41,869,911	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/6/2013 2:18 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0			1.00	
2.00	Land Improvements	1,218,392	0			2.00	
3.00	Buildings and Fixtures	30,840,314	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	9,811,205	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	41,869,911	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	41,869,911	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	1,912,547			1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	752,264			2.00	
3.00	Total (sum of lines 1-2)	0	2,664,811			3.00	
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	47,653	2,102,079	-754,972	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	14,584	745,926	783,348	2.00
3.00	Total (sum of lines 1-2)	0	0	62,237	2,848,005	28,376	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/6/2013 2:18 pm

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	-52,189	47,653	0	0	1,342,571	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3,185	14,584	0	0	1,540,673	2.00
3.00	Total (sum of lines 1-2)	-55,374	62,237	0	0	2,883,244	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
1.00	2.00	3.00	4.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-52,189	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,185	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-8,347	NURSING ADMINISTRATION	13.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,570,873		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-145	RADIOLOGY-DIAGNOSTIC	54.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-138,525		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-133,272	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients	B	-222,348	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00 Sale of medical records and abstracts	B	-17,659	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-5,587	DIETARY	10.00 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		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist	A		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		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 NON-PHYSICIAN ANESTHETIST	A	-496,465	NONPHYSICIAN ANESTHETISTS	19.00 33.00
35.00 CRNA RELATED BENEFITS	A	-101,269	EMPLOYEE BENEFITS	4.00 35.00
44.00 LOBBYING EXPENSE	A	-16,352	ADMINISTRATIVE & GENERAL	5.00 44.00
45.00 ADVERTISING OFFSET SALARY	A	-42,969	ADMINISTRATIVE & GENERAL	5.00 45.00
45.01 ADVERTISING OFFSET OTHER EXP	A	-148,867	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02 AMBULANCE REIMBURSEMENT	B	-24,736	AMBULANCE SERVICES	95.00 45.02
45.03 HEALTH FAIR TESTS INCOME-LAB	A	-81,116	ADMINISTRATIVE & GENERAL	5.00 45.03
45.04 OTHER BEHAVIORAL HEALTH REVENUE	B	-1,876	SUBPROVIDER - I PF	40.00 45.04
45.05 OTHER REVENUE GMA ADMIN	B	-4,225	RURAL HEALTH CLINIC	88.00 45.05
45.06 VENDING MACHINES	B	-48	HOUSEKEEPING	9.00 45.06
45.07 VARIOUS ADMINISTRATIVE	B	215	ADMINISTRATIVE & GENERAL	5.00 45.07
45.08 CLINIC PROPERTY RENTAL	B	-136,868	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.08
45.09		0		0.00 45.09
45.10 RENT	B	-2,500	RADIOLOGY-DIAGNOSTIC	54.00 45.10
45.11 EDUCATION SEMINARS	B	-3,950	RURAL HEALTH CLINIC	88.00 45.11
45.12 ADVERTISING OFFSET-EMPLOYEE BENEFITS	A	-10,639	EMPLOYEE BENEFITS	4.00 45.12
45.13		0		0.00 45.13
45.14 GREEN TEAM SAVINGS	B	-50	ADMINISTRATIVE & GENERAL	5.00 45.14
45.16 TELEPHONE SERVICE	A	-9,485	MAINTENANCE & REPAIRS	6.00 45.16

Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet A-8 Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center			Line #
			1.00	2.00		3.00
45.17 TELEPHONE SERVICE	A	-6,338	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.17	
45.23 NUTRITION COUNSEL REVENUE	B	-4,730	DIETARY	10.00	45.23	
45.25 BARBER AND BEAUTY EXPENSE	A	-7,124	ADMINISTRATIVE & GENERAL	5.00	45.25	
45.27 EDUCATION SEMINARS	B	-660	NURSING ADMINISTRATION	13.00	45.27	
45.28 EDUCATION SEMINARS	B	-550	CLINIC	90.00	45.28	
45.29 CPAP SETUPS NON PATIENT	B	-1,030	RESPIRATORY THERAPY	65.00	45.29	
45.30 CATERING REVENUE	B	-40,529	DIETARY	10.00	45.30	
45.31		0		0.00	45.31	
45.32		0		0.00	45.32	
45.33 MISC SUPPLY REVENUE	B	-8,176	DRUGS CHARGED TO PATIENTS	73.00	45.33	
45.34 MISC SUPPLY REVENUE	B	-416	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	45.34	
45.35 SELF INSURANCE ADJUSTMENT	A	-928,810	EMPLOYEE BENEFITS	4.00	45.35	
45.36		0		0.00	45.36	
45.37		0		0.00	45.37	
45.38 COMMUNITY HEALTH EVENTS INCOME	B	-6,006	LABORATORY	60.00	45.38	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,237,699			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00 NON-PHYSICIAN ANESTHETIST	0	33.00
35.00 CRNA RELATED BENEFITS	0	35.00
44.00 LOBBYING EXPENSE	0	44.00
45.00 ADVERTISING OFFSET SALARY	0	45.00
45.01 ADVERTISING OFFSET OTHER EXP	0	45.01
45.02 AMBULANCE REIMBURSEMENT	0	45.02
45.03 HEALTH FAIR TESTS INCOME-LAB	0	45.03
45.04 OTHER BEHAVIORAL HEALTH REVENUE	0	45.04
45.05 OTHER REVENUE GMA ADMIN	0	45.05
45.06 VENDING MACHINES	0	45.06
45.07 VARIOUS ADMINISTRATIVE	0	45.07
45.08 CLINIC PROPERTY RENTAL	9	45.08
45.09	0	45.09
45.10 RENT	0	45.10
45.11 EDUCATION SEMINARS	0	45.11
45.12 ADVERTISING OFFSET-EMPLOYEE BENEFITS	0	45.12
45.13	0	45.13
45.14 GREEN TEAM SAVINGS	0	45.14
45.16 TELEPHONE SERVICE	0	45.16
45.17 TELEPHONE SERVICE	9	45.17
45.23 NUTRITION COUNSEL REVENUE	0	45.23
45.25 BARBER AND BEAUTY EXPENSE	0	45.25
45.27 EDUCATION SEMINARS	0	45.27
45.28 EDUCATION SEMINARS	0	45.28
45.29 CPAP SETUPS NON PATIENT	0	45.29
45.30 CATERING REVENUE	0	45.30
45.31	0	45.31
45.32	0	45.32

ADJUSTMENTS TO EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.33	MISC SUPPLY REVENUE	0	45.33
45.34	MISC SUPPLY REVENUE	0	45.34
45.35	SELF INSURANCE ADJUSTMENT	0	45.35
45.36		0	45.36
45.37		0	45.37
45.38	COMMUNITY HEALTH EVENTS INCOME	0	45.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/6/2013 2:18 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	GFW RHC LEASE EXPENSE	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	GMA RHC LEASE EXPENSE	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	GFW-MG RHC LEASE EXPENSE	3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	GMA-KEYESPORT RHC LEASE	4.00
4.01	1.00	NEW CAP REL COSTS-BLDG & FIXT	MDH RHC LEASE EXPENSE	4.01
4.02	1.00	NEW CAP REL COSTS-BLDG & FIXT	MDH POKEY RHC LEASE EXPENSE	4.02
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	3.00	

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	B	GREENVILLE REGI	100.00	6.00
7.00			0.00	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:			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: 140137

Period: From 01/01/2012 To 12/31/2012

Worksheet A-8-1

Date/Time Prepared: 5/6/2013 2:18 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
						4.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	23,584	59,064	-35,480	9	1.00	
2.00	26,892	60,192	-33,300	9	2.00	
3.00	10,081	26,004	-15,923	9	3.00	
4.00	284	17,160	-16,876	9	4.00	
4.01	66,860	86,580	-19,720	9	4.01	
4.02	5,190	22,416	-17,226	9	4.02	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		132,891	271,416	-138,525	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		0.00	6.00
7.00		0.00	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:		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: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/6/2013 2:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	18,560	18,560	1.00
2.00	90.00	CLINIC	22,900	22,900	2.00
3.00	69.00	ELECTROCARDIOLOGY	46,821	46,821	3.00
4.00	91.00	EMERGENCY	1,388,006	1,388,006	4.00
5.00	60.00	LABORATORY	6,250	6,250	5.00
6.00	40.00	SUBPROVIDER - IPF	89,645	89,645	6.00
7.00	65.00	RESPIRATORY THERAPY	455	455	7.00
8.00	4.00	EMPLOYEE BENEFITS	65,442	65,442	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	8,100	8,100	9.00
10.00	30.00	ADULTS & PEDIATRICS	636,374	636,374	10.00
11.00	50.00	OPERATING ROOM	0	0	11.00
12.00	75.01	SNR DAY TREATMENT- WHITE OAKS	24,000	24,000	12.00
13.00	88.00	RURAL HEALTH CLINIC	264,320	264,320	13.00
200.00			2,570,873	2,570,873	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/6/2013 2:18 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	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
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/6/2013 2:18 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 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
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2
Date/Time Prepared:
5/6/2013 2:18 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	18,560	1.00
2.00	0	22,900	2.00
3.00	0	46,821	3.00
4.00	0	1,388,006	4.00
5.00	0	6,250	5.00
6.00	0	89,645	6.00
7.00	0	455	7.00
8.00	0	65,442	8.00
9.00	0	8,100	9.00
10.00	0	636,374	10.00
11.00	0	0	11.00
12.00	0	24,000	12.00
13.00	0	264,320	13.00
200.00	0	2,570,873	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

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			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,342,571	1,342,571			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,540,673		1,540,673		2.00
4.00 00400	EMPLOYEE BENEFITS	3,533,145	1,536	1,762	3,536,443	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,303,147	90,947	104,367	451,696	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,221,368	90,910	104,324	61,443	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	171,252	11,148	12,793	28,916	8.00
9.00 00900	HOUSEKEEPING	446,498	16,292	18,696	78,627	9.00
10.00 01000	DIETARY	644,089	38,214	43,853	74,237	10.00
11.00 01100	CAFETERIA	173,458	11,760	13,495	31,087	11.00
13.00 01300	NURSING ADMINISTRATION	567,964	49,300	56,574	111,893	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	113,617	88,163	101,172	20,924	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	405,980	29,338	33,667	78,224	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,405,599	119,860	137,546	231,075	30.00
40.00 04000	SUBPROVIDER - I/PF	621,392	50,061	57,448	122,521	40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	298,873	2,984	3,424	53,818	43.00
44.00 04400	SKILLED NURSING FACILITY	102,996	24,569	28,194	18,774	44.00
45.00 04500	NURSING FACILITY	1,612,216	0	0	293,919	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	800,786	102,807	117,977	126,111	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	77,239	11,223	12,879	13,908	52.00
53.00 05300	ANESTHESIOLOGY	31,854	1,024	1,175	1,163	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,185,420	77,389	88,808	118,644	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,497,086	31,685	36,360	124,063	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	177,681	27,290	31,317	33,928	65.00
66.00 06600	PHYSICAL THERAPY	559,899	20,050	23,008	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	219,575	8,002	9,183	0	67.00
68.00 06800	SPEECH PATHOLOGY	98,184	3,583	4,112	0	68.00
69.00 06900	ELECTROCARDIOLOGY	90,877	1,598	1,834	17,969	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	413,866	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	39,980	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,401,833	22,372	25,673	83,734	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	235,763	22,222	25,501	28,437	75.01
76.97 07697	CARDIAC REHABILITATION	11,255	4,944	5,673	2,187	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,875,658	259,707	298,029	909,860	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03 08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04 08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
88.05 08805	RURAL HEALTH CLINIC VI	0	0	0	0	88.05
90.00 09000	CLINIC	100,675	49,812	57,162	20,126	90.00
90.01 09001	WELLNESS LINK	0	0	0	0	90.01
91.00 09100	EMERGENCY	596,907	28,514	32,721	112,364	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	590,592	19,375	22,234	111,832	95.00
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,509,968	1,316,679	1,510,961	3,361,480	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	775,372	15,168	17,406	151,302	192.00
193.00 19300	NONPAID WORKERS	246,673	10,724	12,306	10,025	193.00
194.00 07950	EMERALD POINT	409,679	0	0	13,636	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
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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			
	0	1.00	2.00	4.00	4A	
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)	32,941,692	1,342,571	1,540,673	3,536,443	32,941,692	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,950,157				5.00
6.00	00600	MAINTENANCE & REPAIRS	261,385	1,739,430			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,633	12,565	276,307		8.00
9.00	00900	HOUSEKEEPING	99,053	18,362	22,709	700,237	9.00
10.00	01000	DIETARY	141,546	43,070	4,515	17,652	1,007,176
11.00	01100	CAFETERIA	40,639	13,254	2,572	5,432	0
13.00	01300	NURSING ADMINISTRATION	138,953	55,564	0	22,773	0
14.00	01400	CENTRAL SERVICES & SUPPLY	57,276	99,365	3,616	40,725	0
16.00	01600	MEDICAL RECORDS & LIBRARY	96,771	33,066	0	13,552	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	334,959	135,090	34,359	55,367	240,189
40.00	04000	SUBPROVIDER - I/PF	150,570	56,422	11,349	23,125	46,946
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	63,505	3,363	758	1,378	0
44.00	04400	SKILLED NURSING FACILITY	30,865	27,691	8,954	11,349	35,369
45.00	04500	NURSING FACILITY	337,090	432,962	140,000	177,452	553,030
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	202,962	115,870	10,030	47,490	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,381	12,649	9,090	5,184	0
53.00	05300	ANESTHESIOLOGY	6,228	1,154	0	473	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,008	87,223	5,071	35,749	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	298,726	35,711	3,865	14,636	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	47,786	30,758	1,310	12,606	0
66.00	06600	PHYSICAL THERAPY	106,630	22,597	4,565	9,262	0
67.00	06700	OCCUPATIONAL THERAPY	41,870	9,019	0	3,697	0
68.00	06800	SPEECH PATHOLOGY	18,724	4,038	0	1,655	0
69.00	06900	ELECTROCARDIOLOGY	19,856	1,801	0	738	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,190	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,070	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	271,212	25,214	0	10,334	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	55,162	25,045	0	10,265	0
76.97	07697	CARDIAC REHABILITATION	4,255	5,572	0	2,284	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,121,765	292,707	1,263	119,967	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0
90.00	09000	CLINIC	40,281	56,141	176	23,010	0
90.01	09001	WELLNESS LINK	0	0	0	0	0
91.00	09100	EMERGENCY	136,260	32,137	10,456	13,171	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	131,579	21,837	1,649	8,950	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,656,190	1,710,247	276,307	688,276	875,534
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	169,638	17,096	0	7,007	0
193.00	19300	NONPAID WORKERS	49,468	12,087	0	4,954	0
194.00	07950	EMERALD POINT	74,861	0	0	0	131,642
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,950,157	1,739,430	276,307	700,237	1,007,176

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	291,697					11.00
13.00	01300	21,439	1,024,460				13.00
14.00	01400	3,172	0	528,030			14.00
16.00	01600	11,393	0	513	702,504		16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,647	123,986	27,574	29,068	0	30.00
40.00	04000	0	69,483	3,796	18,427	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	5,364	22,868	0	2,434	0	43.00
44.00	04400	5,037	14,625	0	2,005	0	44.00
45.00	04500	78,768	228,675	29,039	31,349	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	12,760	54,403	48,325	53,485	0	50.00
52.00	05200	1,386	5,910	0	6,293	0	52.00
53.00	05300	0	0	1,339	12,927	0	53.00
54.00	05400	11,746	50,082	7,191	157,804	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	14,727	62,791	170,858	120,278	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,883	25,867	3,285	14,125	0	65.00
66.00	06600	0	0	3,117	31,075	0	66.00
67.00	06700	0	0	0	14,256	0	67.00
68.00	06800	0	0	0	5,320	0	68.00
69.00	06900	2,184	0	0	10,829	0	69.00
71.00	07100	0	0	163,332	13,355	0	71.00
72.00	07200	0	0	15,762	1,866	0	72.00
73.00	07300	3,953	16,853	0	64,543	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	4,426	18,869	188	8,662	0	75.01
76.97	07697	228	973	79	586	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	48,509	213,708	26,375	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
88.02	08802	0	0	0	0	0	88.02
88.03	08803	0	0	0	0	0	88.03
88.04	08804	0	0	0	0	0	88.04
88.05	08805	0	0	0	0	0	88.05
90.00	09000	2,944	0	537	1,246	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	9,429	44,570	18,784	72,207	0	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	60,367	4,852	30,364	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		269,995	1,014,030	524,946	702,504	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	20,738	0	2,386	0	0	192.00
193.00	19300	964	0	301	0	0	193.00
194.00	07950	0	10,430	397	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		291,697	1,024,460	528,030	702,504	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,903,319	0	2,903,319
40.00	04000	SUBPROVIDER - I/PF	1,231,540	0	1,231,540
41.00	04100	SUBPROVIDER - I/RF	0	0	0
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	458,769	0	458,769
44.00	04400	SKILLED NURSING FACILITY	310,428	0	310,428
45.00	04500	NURSING FACILITY	3,914,500	0	3,914,500
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,693,006	0	1,693,006
52.00	05200	DELIVERY ROOM & LABOR ROOM	176,142	0	176,142
53.00	05300	ANESTHESIOLOGY	57,337	0	57,337
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,085,135	0	2,085,135
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0
60.00	06000	LABORATORY	2,410,786	0	2,410,786
60.01	06001	BLOOD LABORATORY	0	0	0
65.00	06500	RESPIRATORY THERAPY	409,836	0	409,836
66.00	06600	PHYSICAL THERAPY	780,203	0	780,203
67.00	06700	OCCUPATIONAL THERAPY	305,602	0	305,602
68.00	06800	SPEECH PATHOLOGY	135,616	0	135,616
69.00	06900	ELECTROCARDIOLOGY	147,686	0	147,686
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	663,743	0	663,743
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	64,678	0	64,678
73.00	07300	DRUGS CHARGED TO PATIENTS	1,925,721	0	1,925,721
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	434,540	0	434,540
76.97	07697	CARDIAC REHABILITATION	38,036	0	38,036
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,167,548	0	8,167,548
88.01	08801	RURAL HEALTH CLINIC II	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0
90.00	09000	CLINIC	352,110	0	352,110
90.01	09001	WELLNESS LINK	0	0	0
91.00	09100	EMERGENCY	1,107,520	0	1,107,520
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,003,631	0	1,003,631
99.10	09910	CORF	0	0	0
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0
113.00	11300	INTEREST EXPENSE			
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,777,432	0	30,777,432
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,176,113	0	1,176,113
193.00	19300	NONPAID WORKERS	347,502	0	347,502
194.00	07950	EMERALD POINT	640,645	0	640,645
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	32,941,692	0	32,941,692		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
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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	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	1,536	1,762	3,298	3,298 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	90,947	104,367	195,314	421 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	90,910	104,324	195,234	57 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,148	12,793	23,941	27 8.00
9.00 00900	HOUSEKEEPING	0	16,292	18,696	34,988	73 9.00
10.00 01000	DIETARY	0	38,214	43,853	82,067	69 10.00
11.00 01100	CAFETERIA	0	11,760	13,495	25,255	29 11.00
13.00 01300	NURSING ADMINISTRATION	0	49,300	56,574	105,874	104 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	88,163	101,172	189,335	19 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	29,338	33,667	63,005	73 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	119,860	137,546	257,406	215 30.00
40.00 04000	SUBPROVIDER - IPF	0	50,061	57,448	107,509	114 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	2,984	3,424	6,408	50 43.00
44.00 04400	SKILLED NURSING FACILITY	0	24,569	28,194	52,763	17 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	274 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	102,807	117,977	220,784	117 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	11,223	12,879	24,102	13 52.00
53.00 05300	ANESTHESIOLOGY	0	1,024	1,175	2,199	1 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	77,389	88,808	166,197	110 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	31,685	36,360	68,045	116 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	27,290	31,317	58,607	32 65.00
66.00 06600	PHYSICAL THERAPY	0	20,050	23,008	43,058	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	8,002	9,183	17,185	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	3,583	4,112	7,695	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,598	1,834	3,432	17 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	22,372	25,673	48,045	78 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	0	22,222	25,501	47,723	26 75.01
76.97 07697	CARDIAC REHABILITATION	0	4,944	5,673	10,617	2 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	259,707	298,029	557,736	853 88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02 08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
88.03 08803	RURAL HEALTH CLINIC IV	0	0	0	0	0 88.03
88.04 08804	RURAL HEALTH CLINIC V	0	0	0	0	0 88.04
88.05 08805	RURAL HEALTH CLINIC VI	0	0	0	0	0 88.05
90.00 09000	CLINIC	0	49,812	57,162	106,974	19 90.00
90.01 09001	WELLNESS LINK	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	0	28,514	32,721	61,235	105 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	19,375	22,234	41,609	104 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,316,679	1,510,961	2,827,640	3,135 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	15,168	17,406	32,574	141 192.00
193.00 19300	NONPAID WORKERS	0	10,724	12,306	23,030	9 193.00
194.00 07950	EMERALD POINT	0	0	0	0	13 194.00
200.00	Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,342,571	1,540,673	2,883,244	3,298,202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	195,735					5.00
6.00	00600	10,336	205,627				6.00
8.00	00800	1,567	1,485	27,020			8.00
9.00	00900	3,917	2,171	2,221	43,370		9.00
10.00	01000	5,597	5,091	441	1,093	94,358	10.00
11.00	01100	1,607	1,567	252	336	0	11.00
13.00	01300	5,495	6,569	0	1,410	0	13.00
14.00	01400	2,265	11,747	354	2,522	0	14.00
16.00	01600	3,827	3,909	0	839	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,245	15,970	3,360	3,429	22,502	30.00
40.00	04000	5,954	6,670	1,110	1,432	4,398	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	2,511	398	74	85	0	43.00
44.00	04400	1,221	3,273	876	703	3,314	44.00
45.00	04500	13,330	51,181	13,690	10,993	51,811	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,026	13,698	981	2,941	0	50.00
52.00	05200	806	1,495	889	321	0	52.00
53.00	05300	246	136	0	29	0	53.00
54.00	05400	10,282	10,311	496	2,214	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	11,813	4,222	378	907	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	1,890	3,636	128	781	0	65.00
66.00	06600	4,216	2,671	446	574	0	66.00
67.00	06700	1,656	1,066	0	229	0	67.00
68.00	06800	740	477	0	103	0	68.00
69.00	06900	785	213	0	46	0	69.00
71.00	07100	2,894	0	0	0	0	71.00
72.00	07200	280	0	0	0	0	72.00
73.00	07300	10,725	2,981	0	640	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	2,181	2,961	0	636	0	75.01
76.97	07697	168	659	0	141	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	44,347	34,602	124	7,430	0	88.00
88.01	08801	0	0	0	0	0	88.01
88.02	08802	0	0	0	0	0	88.02
88.03	08803	0	0	0	0	0	88.03
88.04	08804	0	0	0	0	0	88.04
88.05	08805	0	0	0	0	0	88.05
90.00	09000	1,593	6,637	17	1,425	0	90.00
90.01	09001	0	0	0	0	0	90.01
91.00	09100	5,388	3,799	1,022	816	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	5,203	2,582	161	554	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		184,111	202,177	27,020	42,629	82,025	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	6,708	2,021	0	434	0	192.00
193.00	19300	1,956	1,429	0	307	0	193.00
194.00	07950	2,960	0	0	0	12,333	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		195,735	205,627	27,020	43,370	94,358	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	29,046					11.00
13.00	01300	2,135	121,587				13.00
14.00	01400	316	0	206,558			14.00
16.00	01600	1,134	0	201	72,988		16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,853	14,715	10,786	3,020		30.00
40.00	04000	0	8,246	1,485	1,915		40.00
41.00	04100	0	0	0	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	534	2,714	0	253		43.00
44.00	04400	502	1,736	0	208		44.00
45.00	04500	7,842	27,141	11,360	3,257		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,271	6,457	18,904	5,557		50.00
52.00	05200	138	701	0	654		52.00
53.00	05300	0	0	524	1,343		53.00
54.00	05400	1,170	5,944	2,813	16,393		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	0	0	0		59.00
60.00	06000	1,466	7,452	66,838	12,497		60.00
60.01	06001	0	0	0	0		60.01
65.00	06500	387	3,070	1,285	1,468		65.00
66.00	06600	0	0	1,219	3,229		66.00
67.00	06700	0	0	0	1,481		67.00
68.00	06800	0	0	0	553		68.00
69.00	06900	217	0	0	1,125		69.00
71.00	07100	0	0	63,893	1,388		71.00
72.00	07200	0	0	6,166	194		72.00
73.00	07300	394	2,000	0	6,706		73.00
75.00	07500	0	0	0	0		75.00
75.01	07501	441	2,239	74	900		75.01
76.97	07697	23	115	31	61		76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	4,830	25,364	10,317	0		88.00
88.01	08801	0	0	0	0		88.01
88.02	08802	0	0	0	0		88.02
88.03	08803	0	0	0	0		88.03
88.04	08804	0	0	0	0		88.04
88.05	08805	0	0	0	0		88.05
90.00	09000	293	0	210	129		90.00
90.01	09001	0	0	0	0		90.01
91.00	09100	939	5,290	7,348	7,502		91.00
92.00	09200						92.00
93.00	04040	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	7,165	1,898	3,155		95.00
99.10	09910	0	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0		109.00
110.00	11000	0	0	0	0		110.00
111.00	11100	0	0	0	0		111.00
113.00	11300						113.00
118.00		26,885	120,349	205,352	72,988	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	2,065	0	933	0		192.00
193.00	19300	96	0	118	0		193.00
194.00	07950	0	1,238	155	0		194.00
200.00							200.00
201.00		0	0	0	0		201.00
202.00		29,046	121,587	206,558	72,988	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	347,501	0	347,501	30.00
40.00	04000	138,833	0	138,833	40.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	13,027	0	13,027	43.00
44.00	04400	64,613	0	64,613	44.00
45.00	04500	190,879	0	190,879	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	278,736	0	278,736	50.00
52.00	05200	29,119	0	29,119	52.00
53.00	05300	4,478	0	4,478	53.00
54.00	05400	215,930	0	215,930	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	173,734	0	173,734	60.00
60.01	06001	0	0	0	60.01
65.00	06500	71,284	0	71,284	65.00
66.00	06600	55,413	0	55,413	66.00
67.00	06700	21,617	0	21,617	67.00
68.00	06800	9,568	0	9,568	68.00
69.00	06900	5,835	0	5,835	69.00
71.00	07100	68,175	0	68,175	71.00
72.00	07200	6,640	0	6,640	72.00
73.00	07300	71,569	0	71,569	73.00
75.00	07500	0	0	0	75.00
75.01	07501	57,181	0	57,181	75.01
76.97	07697	11,817	0	11,817	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	685,603	0	685,603	88.00
88.01	08801	0	0	0	88.01
88.02	08802	0	0	0	88.02
88.03	08803	0	0	0	88.03
88.04	08804	0	0	0	88.04
88.05	08805	0	0	0	88.05
90.00	09000	117,297	0	117,297	90.00
90.01	09001	0	0	0	90.01
91.00	09100	93,444	0	93,444	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	62,431	0	62,431	95.00
99.10	09910	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
118.00		2,794,724	0	2,794,724	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	44,876	0	44,876	192.00
193.00	19300	26,945	0	26,945	193.00
194.00	07950	16,699	0	16,699	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118-201)	2,883,244	0	2,883,244		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/6/2013 2:18 pm

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				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	107,542					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		107,542				2.00
4.00 00400	EMPLOYEE BENEFITS	123	123	16,718,464			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,285	7,285	2,135,384	-4,950,157	27,991,535	5.00
6.00 00600	MAINTENANCE & REPAIRS	7,282	7,282	290,472	0	1,478,045	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	893	893	136,701	0	224,109	8.00
9.00 00900	HOUSEKEEPING	1,305	1,305	371,709	0	560,113	9.00
10.00 01000	DIETARY	3,061	3,061	350,952	0	800,393	10.00
11.00 01100	CAFETERIA	942	942	146,961	0	229,800	11.00
13.00 01300	NURSING ADMINISTRATION	3,949	3,949	528,971	0	785,731	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,062	7,062	98,920	0	323,876	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,350	2,350	369,802	0	547,209	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	9,601	9,601	1,092,405	0	1,894,080	30.00
40.00 04000	SUBPROVIDER - IPF	4,010	4,010	579,216	0	851,422	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	239	239	254,424	0	359,099	43.00
44.00 04400	SKILLED NURSING FACILITY	1,968	1,968	88,752	0	174,533	44.00
45.00 04500	NURSING FACILITY	0	0	1,389,499	0	1,906,135	45.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	8,235	8,235	596,187	0	1,147,681	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	899	899	65,752	0	115,249	52.00
53.00 05300	ANESTHESIOLOGY	82	82	5,500	0	35,216	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,199	6,199	560,889	0	1,470,261	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,538	2,538	586,507	0	1,689,194	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	2,186	2,186	160,393	0	270,216	65.00
66.00 06600	PHYSICAL THERAPY	1,606	1,606	0	0	602,957	66.00
67.00 06700	OCCUPATIONAL THERAPY	641	641	0	0	236,760	67.00
68.00 06800	SPEECH PATHOLOGY	287	287	0	0	105,879	68.00
69.00 06900	ELECTROCARDIOLOGY	128	128	84,947	0	112,278	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	413,866	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	39,980	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,792	1,792	395,852	0	1,533,612	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 07501	SNR DAY TREATMENT- WHITE OAKS	1,780	1,780	134,435	0	311,923	75.01
76.97 07697	CARDIAC REHABILITATION	396	396	10,340	0	24,059	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	20,803	20,803	4,301,329	0	6,343,254	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03 08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04 08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05 08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00 09000	CLINIC	3,990	3,990	95,145	0	227,775	90.00
90.01 09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00 09100	EMERGENCY	2,284	2,284	531,198	0	770,506	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	1,552	1,552	528,685	0	744,033	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	105,468	105,468	15,891,327	-4,950,157	26,329,244	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,215	1,215	715,279	0	959,248	192.00
193.00 19300	NONPAID WORKERS	859	859	47,394	0	279,728	193.00
194.00 07950	EMERALD POINT	0	0	64,464	0	423,315	194.00
200.00	Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/6/2013 2:18 pm

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				
201.00	Negative Cost Centers				5A	5.00	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,342,571	1,540,673	3,536,443		4,950,157	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.484155	14.326245	0.211529		0.176845	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			3,298		195,735	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000197		0.006993	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	123,623				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	893	502,902			8.00
9.00	00900	HOUSEKEEPING	1,305	41,333	121,425		9.00
10.00	01000	DIETARY	3,061	8,217	3,061	122,674	10.00
11.00	01100	CAFETERIA	942	4,681	942	0	533,017
13.00	01300	NURSING ADMINISTRATION	3,949	0	3,949	0	39,175
14.00	01400	CENTRAL SERVICES & SUPPLY	7,062	6,581	7,062	0	5,797
16.00	01600	MEDICAL RECORDS & LIBRARY	2,350	0	2,350	0	20,818
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,601	62,536	9,601	29,255	52,346
40.00	04000	SUBPROVIDER - IPF	4,010	20,656	4,010	5,718	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	239	1,379	239	0	9,801
44.00	04400	SKILLED NURSING FACILITY	1,968	16,297	1,968	4,308	9,205
45.00	04500	NURSING FACILITY	30,771	254,813	30,771	67,359	143,933
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,235	18,256	8,235	0	23,316
52.00	05200	DELIVERY ROOM & LABOR ROOM	899	16,544	899	0	2,533
53.00	05300	ANESTHESIOLOGY	82	0	82	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,199	9,230	6,199	0	21,464
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,538	7,035	2,538	0	26,911
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,186	2,384	2,186	0	7,096
66.00	06600	PHYSICAL THERAPY	1,606	8,308	1,606	0	0
67.00	06700	OCCUPATIONAL THERAPY	641	0	641	0	0
68.00	06800	SPEECH PATHOLOGY	287	0	287	0	0
69.00	06900	ELECTROCARDIOLOGY	128	0	128	0	3,990
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,792	0	1,792	0	7,223
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1,780	0	1,780	0	8,087
76.97	07697	CARDIAC REHABILITATION	396	0	396	0	417
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	20,803	2,299	20,803	0	88,640
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0
90.00	09000	CLINIC	3,990	321	3,990	0	5,379
90.01	09001	WELLNESS LINK	0	0	0	0	0
91.00	09100	EMERGENCY	2,284	19,030	2,284	0	17,230
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,552	3,002	1,552	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,549	502,902	119,351	106,640	493,361
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,215	0	1,215	0	37,895
193.00	19300	NONPAID WORKERS	859	0	859	0	1,761
194.00	07950	EMERALD POINT	0	0	0	16,034	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		6.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,739,430	276,307	700,237	1,007,176	291,697	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.070440	0.549425	5.766827	8.210183	0.547256	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	205,627	27,020	43,370	94,358	29,046	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.663339	0.053728	0.357175	0.769177	0.054494	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	14.00	16.00	19.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	439,064					13.00
14.00	01400	0	1,339,322				14.00
16.00	01600	0	1,302	65,875,285			16.00
19.00	01900	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	53,138	69,939	2,725,766			30.00
40.00	04000	29,779	9,628	1,727,924			40.00
41.00	04100	0	0	0			41.00
42.00	04200	0	0	0			42.00
43.00	04300	9,801	0	228,289			43.00
44.00	04400	6,268	0	188,010			44.00
45.00	04500	98,006	73,655	2,939,684			45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,316	122,573	5,015,449	0		50.00
52.00	05200	2,533	0	590,146	0		52.00
53.00	05300	0	3,396	1,212,217	0		53.00
54.00	05400	21,464	18,240	14,796,774	0		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	0	0	0		59.00
60.00	06000	26,911	433,379	11,278,860	0		60.00
60.01	06001	0	0	0	0		60.01
65.00	06500	11,086	8,331	1,324,568	0		65.00
66.00	06600	0	7,907	2,914,048	0		66.00
67.00	06700	0	0	1,336,811	0		67.00
68.00	06800	0	0	498,838	0		68.00
69.00	06900	0	0	1,015,485	0		69.00
71.00	07100	0	414,282	1,252,380	0		71.00
72.00	07200	0	39,980	174,963	0		72.00
73.00	07300	7,223	0	6,052,457	0		73.00
75.00	07500	0	0	0	0		75.00
75.01	07501	8,087	477	812,290	0		75.01
76.97	07697	417	200	54,991	0		76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	91,591	66,898	0	0		88.00
88.01	08801	0	0	0	0		88.01
88.02	08802	0	0	0	0		88.02
88.03	08803	0	0	0	0		88.03
88.04	08804	0	0	0	0		88.04
88.05	08805	0	0	0	0		88.05
90.00	09000	0	1,361	116,829	0		90.00
90.01	09001	0	0	0	0		90.01
91.00	09100	19,102	47,644	6,771,139	0		91.00
92.00	09200	0	0	0	0		92.00
93.00	04040	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	25,872	12,308	2,847,367	0		95.00
99.10	09910	0	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0		109.00
110.00	11000	0	0	0	0		110.00
111.00	11100	0	0	0	0		111.00
113.00	11300	0	0	0	0		113.00
118.00		434,594	1,331,500	65,875,285	0		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	6,051	0	0		192.00
193.00	19300	0	763	0	0		193.00
194.00	07950	4,470	1,008	0	0		194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		(DIRECT NURSING HRS)	13.00	14.00	16.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	1,024,460	528,030	702,504	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.333282	0.394252	0.010664	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	121,587	206,558	72,988	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.276923	0.154226	0.001108	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		2,903,319		0	2,903,319	30.00
40.00	04000 SUBPROVIDER - IPF		1,231,540		0	1,231,540	40.00
41.00	04100 SUBPROVIDER - IRF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		458,769		0	458,769	43.00
44.00	04400 SKILLED NURSING FACILITY		310,428		0	310,428	44.00
45.00	04500 NURSING FACILITY		3,914,500		0	3,914,500	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,693,006		0	1,693,006	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		176,142		0	176,142	52.00
53.00	05300 ANESTHESIOLOGY		57,337		0	57,337	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,085,135		0	2,085,135	54.00
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		2,410,786		0	2,410,786	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	409,836		0	409,836	65.00
66.00	06600 PHYSICAL THERAPY	0	780,203		0	780,203	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	305,602		0	305,602	67.00
68.00	06800 SPEECH PATHOLOGY	0	135,616		0	135,616	68.00
69.00	06900 ELECTROCARDIOLOGY		147,686		0	147,686	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		663,743		0	663,743	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		64,678		0	64,678	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,925,721		0	1,925,721	73.00
75.00	07500 ASC (NON-DISTINCT PART)		0		0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS		434,540		0	434,540	75.01
76.97	07697 CARDIAC REHABILITATION		38,036		0	38,036	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		8,167,548		0	8,167,548	88.00
88.01	08801 RURAL HEALTH CLINIC II		0		0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III		0		0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV		0		0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V		0		0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI		0		0	0	88.05
90.00	09000 CLINIC		352,110		0	352,110	90.00
90.01	09001 WELLNESS LINK		0		0	0	90.01
91.00	09100 EMERGENCY		1,107,520		0	1,107,520	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		450,197		0	450,197	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		1,003,631		0	1,003,631	95.00
99.10	09910 CORF		0		0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION		0		0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	0	110.00
111.00	11100 ISLET ACQUISITION		0		0	0	111.00
113.00	11300 INTEREST EXPENSE		0		0	0	113.00
200.00	Subtotal (see instructions)		31,227,629	0	0	31,227,629	200.00
201.00	Less Observation Beds		450,197		0	450,197	201.00
202.00	Total (see instructions)		30,777,432	0	0	30,777,432	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,339,896		2,339,896		30.00
40.00	04000	SUBPROVIDER - I/PF	1,727,924		1,727,924		40.00
41.00	04100	SUBPROVIDER - I/RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	228,289		228,289		43.00
44.00	04400	SKILLED NURSING FACILITY	188,010		188,010		44.00
45.00	04500	NURSING FACILITY	2,939,684		2,939,684		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	655,917	4,359,532	5,015,449	0.337558	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	297,301	292,845	590,146	0.298472	52.00
53.00	05300	ANESTHESIOLOGY	407,913	804,304	1,212,217	0.047299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	881,029	13,915,745	14,796,774	0.140918	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,652,458	9,626,402	11,278,860	0.213744	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	368,008	956,560	1,324,568	0.309411	65.00
66.00	06600	PHYSICAL THERAPY	543,103	2,370,945	2,914,048	0.267739	66.00
67.00	06700	OCCUPATIONAL THERAPY	684,184	652,627	1,336,811	0.228605	67.00
68.00	06800	SPEECH PATHOLOGY	299,317	199,521	498,838	0.271864	68.00
69.00	06900	ELECTROCARDIOLOGY	94,979	920,506	1,015,485	0.145434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	365,023	887,357	1,252,380	0.529985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,931	171,032	174,963	0.369667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,490,989	4,561,468	6,052,457	0.318172	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	1,170	812,290	813,460	0.534187	75.01
76.97	07697	CARDIAC REHABILITATION	0	54,991	54,991	0.691677	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,572,079	4,572,079		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0		88.05
90.00	09000	CLINIC	41	116,788	116,829	3.013892	90.00
90.01	09001	WELLNESS LINK	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	498,007	6,273,132	6,771,139	0.163565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,356	339,514	385,870	1.166706	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	194,555	2,652,812	2,847,367	0.352477	95.00
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,908,084	54,540,450	70,448,534		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,908,084	54,540,450	70,448,534		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/6/2013 2:18 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.337558		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.298472		52.00
53.00	05300	ANESTHESIOLOGY	0.047299		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140918		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.213744		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.309411		65.00
66.00	06600	PHYSICAL THERAPY	0.267739		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.228605		67.00
68.00	06800	SPEECH PATHOLOGY	0.271864		68.00
69.00	06900	ELECTROCARDIOLOGY	0.145434		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.369667		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.318172		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.534187		75.01
76.97	07697	CARDIAC REHABILITATION	0.691677		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
90.00	09000	CLINIC	3.013892		90.00
90.01	09001	WELLNESS LINK	0.000000		90.01
91.00	09100	EMERGENCY	0.163565		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166706		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.352477		95.00
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	347,501	25,303	322,198	2,613	123.31	30.00
40.00 04000 SUBPROVIDER - IPF	138,833	0	138,833	1,925	72.12	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 04300 NURSERY	13,027		13,027	383	34.01	43.00
44.00 04400 SKILLED NURSING FACILITY	64,613		64,613	1,436	45.00	44.00
45.00 04500 NURSING FACILITY	190,879		190,879	22,453	8.50	45.00
200.00 Total (lines 30-199)	754,853		729,550	28,810		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	1,166	143,779		30.00
40.00 04000 SUBPROVIDER - IPF	1,870	134,864		40.00
41.00 04100 SUBPROVIDER - IRF	0	0		41.00
42.00 04200 SUBPROVIDER	0	0		42.00
43.00 04300 NURSERY	0	0		43.00
44.00 04400 SKILLED NURSING FACILITY	1,429	64,305		44.00
45.00 04500 NURSING FACILITY	0	0		45.00
200.00 Total (lines 30-199)	4,465	342,948		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part II
Date/Time Prepared:
5/6/2013 2:18 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 XVIII		Capital Costs (column 3 x column 4)
					Hospital	PPS	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	278,736	5,015,449	0.055575	268,248	14,908	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29,119	590,146	0.049342	0	0	52.00
53.00	05300 ANESTHESIOLOGY	4,478	1,212,217	0.003694	5,382	20	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	215,930	14,796,774	0.014593	723,675	10,561	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	173,734	11,278,860	0.015404	923,845	14,231	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	71,284	1,324,568	0.053817	206,692	11,124	65.00
66.00	06600 PHYSICAL THERAPY	55,413	2,914,048	0.019016	26,547	505	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,617	1,336,811	0.016171	44,459	719	67.00
68.00	06800 SPEECH PATHOLOGY	9,568	498,838	0.019181	40,110	769	68.00
69.00	06900 ELECTROCARDIOLOGY	5,835	1,015,485	0.005746	59,315	341	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	68,175	1,252,380	0.054436	183,498	9,989	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,640	174,963	0.037951	3,931	149	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	71,569	6,052,457	0.011825	582,175	6,884	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	57,181	813,460	0.070294	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	11,817	54,991	0.214890	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	685,603	4,572,079	0.149954	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0.000000	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0.000000	0	0	88.05
90.00	09000 CLINIC	117,297	116,829	1.004006	36	36	90.00
90.01	09001 WELLNESS LINK	0	0	0.000000	0	0	90.01
91.00	09100 EMERGENCY	93,444	6,771,139	0.013800	331,913	4,580	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	58,116	385,870	0.150610	32,232	4,854	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,035,556	60,177,364		3,432,058	79,670	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140137		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/6/2013 2:18 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description	Title XVIII					Hospital		PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School				
	6.00	7.00	8.00	9.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,613	0.00	1,166	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	1,925	0.00	1,870	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	0	42.00
43.00	04300	NURSERY	383	0.00	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,436	0.00	1,429	0	0	0	44.00
45.00	04500	NURSING FACILITY	22,453	0.00	0	0	0	0	45.00
200.00		Total (lines 30-199)	28,810		4,465	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/6/2013 2:18 pm
Title XVIII		Hospital	PPS

Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost		
	12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
40.00 04000 SUBPROVIDER - IPF	0	0		40.00
41.00 04100 SUBPROVIDER - IRF	0	0		41.00
42.00 04200 SUBPROVIDER	0	0		42.00
43.00 04300 NURSERY	0	0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
45.00 04500 NURSING FACILITY	0	0		45.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Title XVIII				Hospital	PPS	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	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	5,015,449	0.000000	0.000000	268,248	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	590,146	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,212,217	0.000000	0.000000	5,382	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,796,774	0.000000	0.000000	723,675	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	11,278,860	0.000000	0.000000	923,845	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,324,568	0.000000	0.000000	206,692	65.00
66.00	06600 PHYSICAL THERAPY	0	2,914,048	0.000000	0.000000	26,547	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,336,811	0.000000	0.000000	44,459	67.00
68.00	06800 SPEECH PATHOLOGY	0	498,838	0.000000	0.000000	40,110	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,015,485	0.000000	0.000000	59,315	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,252,380	0.000000	0.000000	183,498	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	174,963	0.000000	0.000000	3,931	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,052,457	0.000000	0.000000	582,175	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	813,460	0.000000	0.000000	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	54,991	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	4,572,079	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00	09000 CLINIC	0	116,829	0.000000	0.000000	36	90.00
90.01	09001 WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	6,771,139	0.000000	0.000000	331,913	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	385,870	0.000000	0.000000	32,232	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	60,177,364			3,432,058	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Title XVIII			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	05000	OPERATING ROOM	0	1,429,928	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	47,074	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,028,560	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	160,619	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	343,131	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	705	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	479,894	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	268,163	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	37,662	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,400,962	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	746,268	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	22,860	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000	CLINIC	0	74,477	0	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	2,033,483	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	123,917	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	13,197,703	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0			75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0			75.01
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0			88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0			88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0			88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0			88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0			88.05
90.00	09000 CLINIC	0	0			90.00
90.01	09001 WELLNESS LINK	0	0			90.01
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0			93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.337558	1,429,928	0	482,684	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.298472	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.047299	47,074	0	2,227	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140918	5,028,560	0	708,615	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.213744	160,619	14	34,331	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.309411	343,131	0	106,169	65.00
66.00	06600 PHYSICAL THERAPY	0.267739	705	0	189	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228605	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.271864	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.145434	479,894	0	69,793	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985	268,163	0	142,122	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.369667	37,662	0	13,922	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.318172	2,400,962	2,651	763,919	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0.534187	746,268	0	398,647	75.01
76.97	07697 CARDIAC REHABILITATION	0.691677	22,860	0	15,812	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000			0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000			0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000			0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000			0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0.000000			0	88.05
90.00	09000 CLINIC	3.013892	74,477	0	224,466	90.00
90.01	09001 WELLNESS LINK	0.000000	0	0	0	90.01
91.00	09100 EMERGENCY	0.163565	2,033,483	0	332,607	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.166706	123,917	0	144,575	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.352477		0		95.00
200.00	Subtotal (see instructions)		13,197,703	2,665	3,440,078	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		13,197,703	2,665	3,440,078	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	3	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	843	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	88.05
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WELLNESS LINK	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
200.00		Subtotal (see instructions)	846	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)	846	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140137 Component CCN: 14S137		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/6/2013 2:18 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	278,736	5,015,449	0.055575	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,119	590,146	0.049342	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,478	1,212,217	0.003694	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,930	14,796,774	0.014593	88,623	1,293	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	173,734	11,278,860	0.015404	290,741	4,479	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	71,284	1,324,568	0.053817	1,697	91	65.00
66.00	06600	PHYSICAL THERAPY	55,413	2,914,048	0.019016	22,718	432	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,617	1,336,811	0.016171	17,297	280	67.00
68.00	06800	SPEECH PATHOLOGY	9,568	498,838	0.019181	25,434	488	68.00
69.00	06900	ELECTROCARDIOLOGY	5,835	1,015,485	0.005746	29,956	172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,175	1,252,380	0.054436	1,383	75	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,640	174,963	0.037951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,569	6,052,457	0.011825	296,537	3,507	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	57,181	813,460	0.070294	1,170	82	75.01
76.97	07697	CARDIAC REHABILITATION	11,817	54,991	0.214890	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	685,603	4,572,079	0.149954	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0.000000	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0.000000	0	0	88.05
90.00	09000	CLINIC	117,297	116,829	1.004006	4	4	90.00
90.01	09001	WELLNESS LINK	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	93,444	6,771,139	0.013800	90,052	1,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	385,870	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,977,440	60,177,364		865,612	12,146	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	5,015,449	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	590,146	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,212,217	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,796,774	0.000000	0.000000	88,623	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	11,278,860	0.000000	0.000000	290,741	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,324,568	0.000000	0.000000	1,697	65.00
66.00	06600 PHYSICAL THERAPY	0	2,914,048	0.000000	0.000000	22,718	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,336,811	0.000000	0.000000	17,297	67.00
68.00	06800 SPEECH PATHOLOGY	0	498,838	0.000000	0.000000	25,434	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,015,485	0.000000	0.000000	29,956	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,252,380	0.000000	0.000000	1,383	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	174,963	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,052,457	0.000000	0.000000	296,537	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	813,460	0.000000	0.000000	1,170	75.01
76.97	07697 CARDIAC REHABILITATION	0	54,991	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	4,572,079	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00	09000 CLINIC	0	116,829	0.000000	0.000000	4	90.00
90.01	09001 WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	6,771,139	0.000000	0.000000	90,052	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	385,870	0.000000	0.000000	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	60,177,364			865,612	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 14S137	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	88.05
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5,015,449	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	590,146	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	1,212,217	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	14,796,774	0.000000	0.000000	22,029	54.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	11,278,860	0.000000	0.000000	43,425	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	1,324,568	0.000000	0.000000	19,383	65.00
66.00 06600 PHYSICAL THERAPY	0	2,914,048	0.000000	0.000000	256,683	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,336,811	0.000000	0.000000	313,531	67.00
68.00 06800 SPEECH PATHOLOGY	0	498,838	0.000000	0.000000	155,435	68.00
69.00 06900 ELECTROCARDIOLOGY	0	1,015,485	0.000000	0.000000	1,244	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,252,380	0.000000	0.000000	1,212	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	174,963	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6,052,457	0.000000	0.000000	166,267	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01 07501 SNR DAY TREATMENT- WHITE OAKS	0	813,460	0.000000	0.000000	0	75.01
76.97 07697 CARDIAC REHABILITATION	0	54,991	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	4,572,079	0.000000	0.000000	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0.000000	0.000000	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV	0	0	0.000000	0.000000	0	88.03
88.04 08804 RURAL HEALTH CLINIC V	0	0	0.000000	0.000000	0	88.04
88.05 08805 RURAL HEALTH CLINIC VI	0	0	0.000000	0.000000	0	88.05
90.00 09000 CLINIC	0	116,829	0.000000	0.000000	0	90.00
90.01 09001 WELLNESS LINK	0	0	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	6,771,139	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	385,870	0.000000	0.000000	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	60,177,364			979,209	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/6/2013 2:18 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501 SNR DAY TREATMENT- WHITE OAKS	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0	0	88.05
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WELLNESS LINK	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (Lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/6/2013 2:18 pm
Cost Center Description		Title XVIII	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)		3,732	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,613	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,176	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,058	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		61	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,166	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)		941	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		192.90	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		119.88	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)		2,903,319	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)		204,088	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)		7,313	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)		211,401	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,691,918	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,339,896	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,339,896	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.150443	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)		1,075.32	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)		2,691,918	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,030.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,201,213	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)		1,201,213	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/6/2013 2:18 pm	
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)	0	0	0.00	0	0	0	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)					866,943		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,068,156		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)					143,779		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					79,670		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					223,449		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,844,707		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)					181,519		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)					181,519		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)					437		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,030.20		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					450,197		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet D-1
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Cost	Title XVIII		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	347,501	2,691,918	0.129090	450,197	58,116	90.00
91.00	Nursing School cost	0	2,691,918	0.000000	450,197	0	91.00
92.00	Allied health cost	0	2,691,918	0.000000	450,197	0	92.00
93.00	All other Medical Education	0	2,691,918	0.000000	450,197	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14S137		Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,925	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,925	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,925	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,870	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)		1,231,540	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,231,540	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,231,540	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)		639.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,196,351	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)		1,196,351	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14S137				Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							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)					206,915		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,403,266		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)					134,864		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,146		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					147,010		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,256,256		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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137 Component CCN: 14S137		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	138,833	1,231,540	0.112731	0	0	90.00
91.00	Nursing School cost	0	1,231,540	0.000000	0	0	91.00
92.00	Allied health cost	0	1,231,540	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,231,540	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 146022		Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,436	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,436	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,436	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,429	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)		310,428	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		310,428	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	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)		310,428	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 146022		Title XVIII		Skilled Nursing Facility	
						Date/Time Prepared: 5/6/2013 2:18 pm	
						PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					310,428	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					216.18	71.00
72.00	Program routine service cost (line 9 x line 71)					308,921	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					308,921	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					308,921	83.00
84.00	Program inpatient ancillary services (see instructions)					254,764	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					563,685	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140137 Component CCN: 146022		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/6/2013 2:18 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,051,308	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.337558	268,248	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.298472	0	52.00
53.00	05300	ANESTHESIOLOGY	0.047299	5,382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140918	723,675	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.213744	923,845	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.309411	206,692	65.00
66.00	06600	PHYSICAL THERAPY	0.267739	26,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.228605	44,459	67.00
68.00	06800	SPEECH PATHOLOGY	0.271864	40,110	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145434	59,315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985	183,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.369667	3,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.318172	582,175	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.534187	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.691677	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	3.013892	36	90.00
90.01	09001	WELLNESS LINK	0.000000	0	90.01
91.00	09100	EMERGENCY	0.163565	331,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166706	32,232	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,432,058	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)		3,432,058	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 14S137		Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
40.00	04000	SUBPROVIDER - IPF		1,701,306	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.337558	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.298472	0	52.00
53.00	05300	ANESTHESIOLOGY	0.047299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140918	88,623	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.213744	290,741	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.309411	1,697	65.00
66.00	06600	PHYSICAL THERAPY	0.267739	22,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.228605	17,297	67.00
68.00	06800	SPEECH PATHOLOGY	0.271864	25,434	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145434	29,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985	1,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.369667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.318172	296,537	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.534187	1,170	75.01
76.97	07697	CARDIAC REHABILITATION	0.691677	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	88.05
90.00	09000	CLINIC	3.013892	4	90.00
90.01	09001	WELLNESS LINK	0.000000	0	90.01
91.00	09100	EMERGENCY	0.163565	90,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166706	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		865,612	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)		865,612	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 14U137		Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIII	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		406,512	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.337558	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.298472	0	52.00
53.00	05300	ANESTHESIOLOGY	0.047299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140918	46,702	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.213744	165,685	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.309411	93,187	65.00
66.00	06600	PHYSICAL THERAPY	0.267739	217,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.228605	272,038	67.00
68.00	06800	SPEECH PATHOLOGY	0.271864	63,618	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145434	4,464	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985	33,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.369667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.318172	203,786	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.534187	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.691677	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
90.00	09000	CLINIC	3.013892	1	90.00
90.01	09001	WELLNESS LINK	0.000000	0	90.01
91.00	09100	EMERGENCY	0.163565	310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166706	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,100,777	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,100,777	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 146022		Date/Time Prepared: 5/6/2013 2:18 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		188,622	30.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.337558	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.298472	0	52.00
53.00	05300	ANESTHESIOLOGY	0.047299	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140918	22,029	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.213744	43,425	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.309411	19,383	65.00
66.00	06600	PHYSICAL THERAPY	0.267739	256,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.228605	313,531	67.00
68.00	06800	SPEECH PATHOLOGY	0.271864	155,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0.145434	1,244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529985	1,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.369667	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.318172	166,267	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SNR DAY TREATMENT- WHITE OAKS	0.534187	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.691677	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	88.05
90.00	09000	CLINIC	3.013892	0	90.00
90.01	09001	WELLNESS LINK	0.000000	0	90.01
91.00	09100	EMERGENCY	0.163565	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.166706	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		979,209	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)		979,209	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/6/2013 2:18 pm
		Title VIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		2,052,062	1.00
2.00	Outlier payments for discharges. (see instructions)		3,113	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		27.75	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.28	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		42.10	31.00
32.00	Sum of lines 30 and 31		46.38	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		246,247	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		2,301,422	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		2,301,422	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		164,784	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,466,206 59.00
60.00	Primary payer payments			11,898 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,454,308 61.00
62.00	Deductibles billed to program beneficiaries			298,200 62.00
63.00	Coinurance billed to program beneficiaries			2,312 63.00
64.00	Allowable bad debts (see instructions)			80,073 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			56,051 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			80,073 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,209,847 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			0 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			411,273 70.96
70.97	Low Volume Payment-2			119,694 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			2,740,814 71.00
72.00	Interim payments			2,730,400 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			10,414 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/6/2013 2:18 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	2,052,062	0	1,582,711	469,351	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	3,113	0	3,113	0	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	246,247	0	189,925	56,322	11.00	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	2,301,422	0	1,775,749	525,673	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	2,301,422	0	1,775,749	525,673	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	164,784	0	127,666	37,118	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	1,903,415	562,791	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	164,154	0	127,036	37,118	20.00	
21.00	Capital DRG outlier payments	2.00	630	0	630	0	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	164,784	0	127,666	37,118	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.216071	0.212679	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			411,273		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				119,694	29.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/6/2013 2:18 pm

Title XVII

Hospital

PPS

		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	2,052,062		1.00
2.00	Outlier payments for discharges (see instructions)	3,113		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
Indirect Medical Education Adjustment				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
Disproportionate Share Adjustment				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	246,247		11.00
Additional payment for high percentage of ESRD beneficiary discharges				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	2,301,422		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	2,301,422		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	164,784		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	2,466,206		19.00
		5.00		
20.00	Capital DRG other than outlier	164,154		20.00
21.00	Capital DRG outlier payments	630		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	164,784		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	411,273		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	119,694		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		846	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,440,078	2.00
3.00	PPS payments		3,074,385	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)		846	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,665	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)		2,665	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 charge basis 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)		2,665	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,819	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)		846	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		3,074,385	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		758,868	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,316,363	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,316,363	30.00
31.00	Primary payer payments		774	31.00
32.00	Subtotal (line 30 minus line 31)		2,315,589	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)		158,046	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		110,632	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		158,046	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,426,221	37.00
38.00	MSP-LCC reconciliation amount from PS&R		571	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,425,650	40.00
41.00	Interim payments		2,394,042	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)		31,608	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: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/6/2013 2:18 pm
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,903,800		2,394,042	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	03/29/2012	31,600		0	3.01	
3.02		10/01/2012	7,200		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	03/13/2013	212,200		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)		-173,400		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,730,400		2,394,042	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		10,414		31,608	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,740,814		2,425,650	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: 140137
Component CCN: 14S137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,363,899			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,363,899			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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		1,363,899			0 7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140137
Component CCN: 14U137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Title XVIII Swing Beds - SNF PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		376,031		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		376,031		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		376,031		0	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: 140137
Component CCN: 146022

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/6/2013 2:18 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		504,378		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		504,378		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		4,638		0	6.02
7.00	Total Medicare program liability (see instructions)		499,740		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part II
Date/Time Prepared:
5/6/2013 2:18 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		826	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		1,166	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		21	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		2,176	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		70,448,534	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		1,710,959	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		838,671	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)		838,671	32.00
			Overrides	
			1.00	
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140137

Period:

Worksheet E-2

Component CCN: 14U137

From 01/01/2012

Date/Time Prepared:

To 12/31/2012

5/6/2013 2:18 pm

		Title XVIII		Swing Beds - SNF		PPS	
		Part A	Part B				
		1.00	2.00				
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	393,516	0				1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)						2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)						3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00				4.00
5.00	Program days	941	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)	393,516	0				8.00
9.00	Primary payer payments (see instructions)	0	0				9.00
10.00	Subtotal (line 8 minus line 9)	393,516	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)	393,516	0				12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,485	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)	376,031	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)	376,031	0				19.00
20.00	Interim payments	376,031	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)	0	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: 140137 Component CCN: 14S137	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,500,215 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.259563 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,500,215 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,500,215 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,500,215 18.00
19.00	Deductibles			130,536 19.00
20.00	Subtotal (line 18 minus line 19)			1,369,679 20.00
21.00	Coinsurance			5,780 21.00
22.00	Subtotal (line 20 minus line 21)			1,363,899 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,363,899 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,363,899 31.00
32.00	Interim payments			1,363,899 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140137 Component CCN: 146022	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		618,170	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		618,170	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		122,392	7.00
8.00	Allowable bad debts (see instructions)		3,962	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		3,962	9.00
10.00	Allowable reimbursable bad debts (see instructions)		3,962	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		499,740	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		499,740	15.00
16.00	Interim payments		504,378	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		-4,638	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/6/2013 2:18 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	1,950,702	0	0	0	1.00
2.00	Temporary investments	507,505	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,292,248	0	0	0	4.00
5.00	Other receivable	916,868	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	483,501	0	0	0	7.00
8.00	Prepaid expenses	300,858	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,451,682	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	1,218,392	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	30,840,314	0	0	0	15.00
16.00	Accumulated depreciation	-21,935,877	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	9,811,205	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	236,799	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,170,833	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,008,846	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	370,390	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,379,236	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,001,751	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,413,768	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,638,789	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	553,700	0	0	0	40.00
41.00	Deferred income	103,523	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,016,679	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,726,459	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,063,839	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,883,885	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,947,724	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,674,183	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,327,568	0	0	0	52.00
53.00	Specific purpose fund	0	0	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)	15,327,568	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,001,751	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/6/2013 2:18 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		14,387,894			0
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,150,572			
3.00	Total (sum of line 1 and line 2)		12,237,322			0
4.00	Additions (credit adjustments) (specify)	0		0		0
5.00	TRANSFER TO AFFILIATES	3,090,245		0		0
6.00		0		0		0
7.00		0		0		0
8.00		0		0		0
9.00		0		0		0
10.00	Total additions (sum of line 4-9)		3,090,245		0	0
11.00	Subtotal (line 3 plus line 10)		15,327,567		0	0
12.00	Deductions (debit adjustments) (specify)	0		0		0
13.00		0		0		0
14.00		0		0		0
15.00		0		0		0
16.00		0		0		0
17.00		0		0		0
18.00	Total deductions (sum of lines 12-17)		0		0	0
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,327,567		0	0

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/6/2013 2:18 pm

	Endowment Fund	Plant Fund			
		6.00	7.00		
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	TRANSFER TO AFFILIATES		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			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: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/6/2013 2:18 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,280,525		3,280,525	1.00
2.00	SUBPROVIDER - IPF	1,727,924		1,727,924	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	462,578		462,578	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	188,010		188,010	7.00
8.00	NURSING FACILITY	2,939,684		2,939,684	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,598,721		8,598,721	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)	8,598,721		8,598,721	17.00
18.00	Ancillary services	8,724,072	51,102,144	59,826,216	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	5,778,876	5,778,876	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
20.02	RURAL HEALTH CLINIC III	0	0	0	20.02
20.03	RURAL HEALTH CLINIC IV	0	0	0	20.03
20.04	RURAL HEALTH CLINIC V	0	0	0	20.04
20.05	RURAL HEALTH CLINIC VI	0	0	0	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	194,555	2,681,894	2,876,449	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	657,207	657,207	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,517,348	60,220,121	77,737,469	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,179,391		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		2,341,291			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)		2,341,291		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	BAD DEBTS	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)		40,520,682		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/6/2013 2:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,737,469	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,729,972	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,007,497	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,520,682	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,513,185	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	55,374	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	312,290	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	OTHER (SPECIFY)	2,994,949	24.00
25.00	Total other income (sum of lines 6-24)	3,362,613	25.00
26.00	Total (line 5 plus line 25)	-2,150,572	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)	-2,150,572	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		164,154	1.00
2.00	Capital DRG outlier payments		630	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		5.95	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		164,784	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/6/2013 2:18 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	2,682,390	0	2,682,390	0	2,682,390	1.00
2.00	Physician Assistant	3,214	0	3,214	0	3,214	2.00
3.00	Nurse Practitioner	569,488	0	569,488	0	569,488	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	526,337	0	526,337	0	526,337	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	98,318	0	98,318	0	98,318	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	3,879,747	0	3,879,747	0	3,879,747	10.00
11.00	Physician Services Under Agreement	0	58,613	58,613	0	58,613	11.00
12.00	Physician Supervision Under Agreement	0	3,600	3,600	0	3,600	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	62,213	62,213	0	62,213	14.00
15.00	Medical Supplies	0	63,946	63,946	0	63,946	15.00
16.00	Transportation (Health Care Staff)	0	17,777	17,777	0	17,777	16.00
17.00	Depreciation-Medical Equipment	0	5,031	5,031	0	5,031	17.00
18.00	Professional Liability Insurance	0	224,666	224,666	0	224,666	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	311,420	311,420	0	311,420	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,879,747	373,633	4,253,380	0	4,253,380	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	33,194	33,194	0	33,194	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	33,194	33,194	0	33,194	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	685,902	175,677	861,579	0	861,579	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	685,902	175,677	861,579	0	861,579	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,565,649	582,504	5,148,153	0	5,148,153	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/6/2013 2:18 pm
		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	-237,326	2,445,064	1.00
2.00	Physician Assistant	0	3,214	2.00
3.00	Nurse Practitioner	0	569,488	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	-26,994	499,343	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	98,318	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	-264,320	3,615,427	10.00
11.00	Physician Services Under Agreement	0	58,613	11.00
12.00	Physician Supervision Under Agreement	0	3,600	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	62,213	14.00
15.00	Medical Supplies	0	63,946	15.00
16.00	Transportation (Health Care Staff)	0	17,777	16.00
17.00	Depreciation-Medical Equipment	0	5,031	17.00
18.00	Professional Liability Insurance	0	224,666	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	311,420	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-264,320	3,989,060	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	33,194	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	33,194	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-8,175	853,404	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,175	853,404	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-272,495	4,875,658	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-2 Date/Time Prepared: 5/6/2013 2:18 pm
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			Rural Health Clinic (RHC) I	Cost
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	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	6.49	23,428	4,200	27,258	1.00
2.00	Physician Assistant	0.01	43	2,100	21	2.00
3.00	Nurse Practitioner	4.09	13,847	2,100	8,589	3.00
4.00	Subtotal (sum of lines 1-3)	10.59	37,318		35,868	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	1.60	1,969		1,969	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)	12.19	39,287		39,287	8.00
9.00	Physician Services Under Agreements		238		238	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)			3,989,060	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)			33,194	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)			4,022,254	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)			0.991747	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)			853,404	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			3,291,890	15.00
16.00	Total overhead (sum of lines 14 and 15)			4,145,294	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Subtract line 17 from line 16			4,145,294	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			4,111,083	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			8,100,143	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-3 Date/Time Prepared: 5/6/2013 2:18 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)		8,100,143	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		49,954	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		8,050,189	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		39,287	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		238	5.00
6.00	Total adjusted visits (line 4 plus line 5)		39,525	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		203.67	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	203.67	203.67	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,696	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,771,114	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1,205	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	245,422	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	184,067	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,955,181	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,289,103	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,209	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		33,684	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,465,719	16.04
16.05	Total program cost (see instructions)		1,499,403	16.05
17.00	Primary payer amounts		1,940	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		89,348	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		267,234	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,497,463	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		26,100	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,523,563	22.00
23.00	Reimbursable bad debts (see instructions)		36,769	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)		1,560,332	26.00
27.00	Interim payments		1,433,844	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)		126,488	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-4 Date/Time Prepared: 5/6/2013 2:18 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	3,615,427	3,615,427	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.003000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	10,846	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,040	10,611	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,040	21,457	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	3,989,060	3,989,060	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	4,145,294	4,145,294	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000762	0.005379	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,159	22,298	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,199	43,755	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	39	719	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	158.95	60.86	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	21	374	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,338	22,762	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		49,954	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		26,100	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140137 Component CCN: 143491	Period: From 01/01/2012 To 12/31/2012	Worksheet M-5 Date/Time Prepared: 5/6/2013 2:18 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,433,844	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,433,844	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		126,488	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,560,332	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

SPECIAL REPORTS - Interns & Residents to Beds Ratio Report

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Interns & Residents

Date/Time Prepared:
5/6/2013 2:18 pm

		1.00	
Subject: Interns & Residents to Beds Ratio Update (Operating IME)			
Interns & Residents to Average Daily Census Ratio Update (Capital IME)			
Please make the following changes in order to update the Provider Specific file:			
Ref: CMS PUB. 100-04, SEC 20.2.3			
INTERNS & RESIDENTS /BEDS RATIO FOR OPERATING PPS			
1.00	Number of Beds (E Pt A Ln 4)	27.75	1.00
2.00	Number of FTE Interns & Residents (E Pt A Ln 15)	0.00	2.00
3.00	Current Yr resident to bed ratio (E Pt A Ln 19)	0.0000	3.00
4.00	Prior Yr resident to bed ratio (E Pt A Ln 20)	0.0000	4.00
5.00	Lesser of Ln 3 or Ln 4 (E Pt A Ln 21)	0.0000	5.00
6.00	Section 422 Add-on FTE (E Pt A Ln 25)	0.00	6.00
7.00	Total IME Payment (E Pt A Ln 29)	0	7.00
8.00	DRG + HMO DRG (E Pt A Lns 1 + 3)	2,052,062	8.00
9.00	FISS PSF Intern to bed ratio $((Ln 7 / Ln 8) / 1.35) + 1)^{(1/0.405)} - 1$	0.0000	9.00
INTERNS & RESIDENTS / Average Daily Census Ratio for Capital PPS			
20.00	Number of FTE Interns & Residents (L, Ln 4)	0.00	20.00
21.00	Average Daily Census for PPS Hospital (L, Ln 3)	5.95	21.00
22.00	Ratio of Interns & Residents / Average Daily Census - Ln 20 / Ln 21 (round to four decimal places)	0.0000	22.00

The information for this update was taken from:

- _____ Information supplied by the provider
- _____ Final Settled Cost Report for FYE: 12/31/2012
- _____ Other (Specify)

SPECIAL REPORTS - PSYCH RATE REPORT		Provider CCN: 140137	Period: From 01/01/2012 To 12/31/2012	PSYCH RATE REPORT Date/Time Prepared: 5/6/2013 2:18 pm
			Hospital	PPS
			1.00	
PSYCH RATIO OF COST TO CHARGES (RCC) REPORT (PER CR7609)				
1.00	Total program cost (D-1 Pt II Line 49.00 minus E-3 Pt II line 28)		1,403,266	1.00
2.00	Total program charges (D-3 Col 2 sum of lines 30-35 if hospital or line 40 if sub-provider plus D-3 Col 2 Line 202; where possible, these charges should be confirmed with the PS&R data)		2,566,918	2.00
3.00	Psych unit Ratio of Cost to Charges (Line 1 divided by line 2)		0.547	3.00
PSYCH RESIDENTS TO AVERAGE DAILY CENSUS REPORT				
11.00	W/S E-3, Pt II Line 8 I&R PPS Med Ed Adj		0.00	11.00
12.00	W/S E-3, Pt II Line 9 Ave Daily Census		5.259563	12.00
13.00	Psych Residents Average Daily Census		0.0000	13.00
PSYCH NATIONAL URBAN & RURAL COST TO CHARGE RATIOS FOR THE IPF PPS FY 2013 (PER CR#8000)				
21.00	Urban Median		0.4960	21.00
22.00	Urban Ceiling		1.7072	22.00
23.00	Rural Median		0.6220	23.00
24.00	Rural Ceiling		1.9155	24.00
BED SIZE				
31.00	Bed Size (W/S S-3, Pt I Line 16 Col 2)		10.00	31.00

SPECIAL REPORTS - OPPS RCC REPORT WITH PARAMED. ED & ALLIED HEALTH COSTS EXCLUDED

Provider CCN: 140137

Period: From 01/01/2012 To 12/31/2012

OPPS RCC Report

Date/Time Prepared: 5/6/2013 2:18 pm

Cost Center Description	Cost/Charge Ratio	PPS Services FYB to 12/31	PPS Services 1/1 to FYE	Total Charges (C)	Total Costs (C)	
	1.00	2.00	2.01	3.00	4.00	
ANCILLARY SERVICE COST CENTERS (B)						
50.00 OPERATING ROOM	0.337558	1,429,928	0	1,429,928	482,684	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.047308	47,074	0	47,074	2,227	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.140918	5,028,560	0	5,028,560	708,615	54.00
57.00 CT SCAN	0.000000	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 LABORATORY	0.213742	160,619	0	160,619	34,331	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0.309412	343,131	0	343,131	106,169	65.00
66.00 PHYSICAL THERAPY (C)	0.268085	705	0	705	189	66.00
67.00 OCCUPATIONAL THERAPY (C)	0.000000	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY (C)	0.000000	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.145434	479,894	0	479,894	69,793	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.529984	268,163	0	268,163	142,122	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.369656	37,662	0	37,662	13,922	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.318172	2,400,962	0	2,400,962	763,919	73.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01 SNR DAY TREATMENT- WHITE OAKS	0.534187	746,268	0	746,268	398,647	75.01
76.97 CARDIAC REHABILITATION	0.691689	22,860	0	22,860	15,812	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC (C)	0.000000	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II (C)	0.000000	0	0	0	0	88.01
88.02 RURAL HEALTH CLINIC III (C)	0.000000	0	0	0	0	88.02
88.03 RURAL HEALTH CLINIC IV (C)	0.000000	0	0	0	0	88.03
88.04 RURAL HEALTH CLINIC V (C)	0.000000	0	0	0	0	88.04
88.05 RURAL HEALTH CLINIC VI (C)	0.000000	0	0	0	0	88.05
90.00 CLINIC	3.013897	74,477	0	74,477	224,466	90.00
90.01 WELLNESS LINK	0.000000	0	0	0	0	90.01
91.00 EMERGENCY	0.163565	2,033,483	0	2,033,483	332,607	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.166708	123,917	0	123,917	144,575	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES (C)	0.000000	0	0	0	0	95.00
202.00 Total		13,196,998	0	13,196,998	3,439,889	202.00
RCC Calculation (B)						
211.00 Total Cost (Col 4, Line 202 which equals D Pt V col 5, Line 200)					3,439,889	211.00
212.00 Total Charges (Col 3, Line 202 which equals D Pt V col 2 and subscripts, Line 200)					13,196,998	212.00
213.00 OPPS / Charge Ratio (OPPS Cost/Charge Ratio Max is 1.400)					0.261	213.00
Statewide Average Operating RCC						
214.00 Urban					0.295	214.00
215.00 Rural					0.360	215.00
Section II - Bed Size						
221.00 Bed Size (E Pt A line 4 logic)					27.75	221.00
Section III - Non Opps RCC for FISS-Core, 41 Screen, Page 3						
231.00 W/S E Part B, line 1, col 1					846	231.00
232.00 W/S E Part B line 12, col 1					2,665	232.00
233.00 Non OPPS RCC (line 231 / line 232)					0.317	233.00

(A) Cost/Charge Ratio Calculated after omitting the Costs for Paramed Ed & Allied Health

(B) Worksheet A line numbers. If lines 96-97 present, review to ensure that "Non Implantable DME" is Excluded

(C) Wks A lines 61, 66-68, 74, 88, 89, 94, 95 are not included in Totals

SPECIAL REPORTS - COST TO CHARGE RATIO REPORT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Cost to Charge Rati
Date/Time Prepared:
5/6/2013 2:18 pm

		1.00	
1.00	Ref:	Change Req #8041	1.00
I. COST TO CHARGE RATIO FOR PPS HOSPITALS			
11.00	Total program (Title XVIII) inpatient operating cost excluding capital related, nonphysician anesthesiologist and medical education cost (Worksheet D-1, Part II, Line 53 minus Line 42 nursery costs)	1,844,707	11.00
12.00	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ancillary charges (D-3 col 2 line 202) for hospital Title XVIII component)	4,483,366	12.00
13.00	Ratio of cost to charges (Line 1/Line 2) (Operating Max is 1.146)	0.411	13.00
II. COST TO CHARGE RATIO FOR CAPITAL			
21.00	Total Medicare inpatient PPS capital related costs (W/S D Part I, Lines 30-35, column 7; Plus D Part II, Line 200, column 5)	223,449	21.00
22.00	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ancillary charges (D-3 col 2 line 202) for hospital Title XVIII component)	4,483,366	22.00
23.00	Ratio of cost to charges (Line 21/Line 22) (Capital Max is 0.166)	0.050	23.00
III. MEDICAID PATIENT DAYS TO TOTAL DAYS			
31.00	Medicaid Patient Days (S-2, Part I Columns 1-6 Line 24)	1,119	31.00
32.00	Total Days (S-3, Part I Column 8 Line 14 + Column 8 Line 32 minus sum of Lines 5-6, plus employee discount days Column 8 Line 30)	2,658	32.00
33.00	Medicaid Ratio (Line 1 divided by Line 2)	0.4210	33.00
IV. BED SIZE			
41.00	Bed Size (W/S E, Part A, Line 4 Logic)	27.75	41.00

SPECIAL REPORTS - PASS THRU PER DIEM REPORT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Pass Thru Per Diem
Date/Time Prepared:
5/6/2013 2:18 pm

		1.00	
MEDICAL EDUCATION PASS-THRU PER DIEM (PTA EDU)			
1.00	Direct Medical Education (E Pt A lines 52 + 53)	0	1.00
2.00	Medicare Days (E-4 line 26 cols 1 + 2)	0	2.00
3.00	Direct Med Ed Pass-Thru Per Diem (line 1 / line 2)	0.00	3.00
4.00	Routine Service Pass-Thru (E Pt A line 57)	0	4.00
5.00	Ancillary Service Pass-Thru (E Pt A Line 58)	0	5.00
6.00	Total Allied Health Education Costs (line 4 + line 5)	0	6.00
7.00	Medicare Days (S-3 Pt I line 14 col 6)	2,107	7.00
8.00	Allied Health Ed Pass-Thru Per Diem (line 6 / line 7)	0.00	8.00
9.00	Total Medical Education Pass-Thru Per Diem (line 3 + line 8)	0.00	9.00
ORGAN ACQUISITION PASS-THRU PER DIEM (PTA ORG)			
10.00	Net Organ Acquisition Cost (E Pt A line 55)	0	10.00
11.00	Medicare Days (S-3 Pt I line 14 col 6)	2,107	11.00
12.00	Organ Acquisition Pass-Thru Per Diem (line 10 / line 11)	0.00	12.00
13.00	Total Pass-Thru Per Diem (line 9 + line 12)	0.00	13.00

SPECIAL REPORTS - HI TECH FISS DATA REPORT

Provider CCN: 140137

Period:
From 01/01/2012
To 12/31/2012

Worksheet HI TECH FI
Date/Time Prepared:
5/6/2013 2:18 pm

		1.00	
1.00	Acceptance Date		1.00
1.01	Is this a CAH?	NO	1.01
CAH DATA FIELDS:			
2.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)		2.00
3.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)		3.00
4.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)		4.00
5.00	Total Charges (C Pt I col 8, line 200)		5.00
6.00	Charity Care (S-10 col 3, line 20)		6.00
		1.00	
7.00	Cost of EHR Equipment (obtained from provider)		7.00
		1.00	
NON-CAH DATA FIELDS:			
8.00	Total Discharges (S-3 Pt I col 15, line 14)	826	8.00
9.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)	1,166	9.00
10.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)	21	10.00
11.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)	2,176	11.00
12.00	Total Charges (C Pt I col 8, line 200)	70,448,534	12.00
13.00	Charity Care (S-10 col 3, line 20)	1,710,959	13.00
		1.00	
14.00	Input into FISS:		14.00
15.00	Date input into FISS:		15.00