

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: 141302
 Period: From 10/01/2011 To 09/30/2012
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 2/25/2013 9:28 am

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 2/25/2013 Time: 9:28 am

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 MIDWEST MEDICAL CENTER (141302) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 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.

Encryption Information

ECR: Date: 2/25/2013 Time: 9:28 am
 t11NE:eD8PhDD03RkwioXDbwQk:d00
 zw1Ge0wwpqHHPROGQTJ:AL0hnlSEL
 Qshk0XvwmX0Ac06P
 PI: Date: 2/25/2013 Time: 9:28 am
 eHb:JKnqlEaRO0VYsAdG06hbt:4hM1
 bgRi50qqrJxvrATHGaQa..s8Y4:XPd
 Yjli4X0v6u0CKQLV

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-20,785	-549,366	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-92,996	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	-84,410	0	0	10.00
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	-113,781	-633,776	0	0	200.00

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



Accountant's Compilation Report

Board of Directors
Midwest Medical Center
Galena, Illinois

We have compiled the Medicare Cost Report ("cost report") for Midwest Medical Center for the year ended September 30, 2012, included in the accompanying prescribed form (Form CMS 2552-10). We have not audited or reviewed the accompanying cost report and, accordingly, do not express an opinion or provide any assurance about whether the cost report is in accordance with the form prescribed by the Centers for Medicare and Medicaid Services.

Management is responsible for the preparation and fair presentation of the cost report in accordance with the basis of accounting prescribed by the Centers for Medicare and Medicaid Services and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the cost report.

Our responsibility is to conduct the compilation in accordance with *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form of a cost report without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the cost report.

The financial information included in the accompanying prescribed form is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, and is not intended to be a complete presentation of Midwest Medical Center's financial position, results of operations, changes in net assets, and cash flows.

This report is intended solely for the information and use of management, the Board of Directors, and the Centers for Medicare and Medicaid Services and is not intended to be and should not be used by anyone other than these specified parties.

A handwritten signature in black ink that reads 'Wipfli LLP'.

Wipfli LLP

February 25, 2013
Eau Claire, Wisconsin

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street:1 MEDICAL CENTER DRIVE	PO Box:								1.00
2.00	City: GALENA	State: IL		Zip Code: 61036-		County: JO DAVIESS				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	MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MIDWEST MEDICAL CENTER	14Z302	99914		02/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N	15.00
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)					10/01/2011	09/30/2012		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.					N		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.					2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible 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.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible 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	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00		
27.00	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.					2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/24/2013 2:54 pm		
		Beginning: 1.00	Ending: 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 1.00	Y/N 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.					39.00
		V 1.00	XVIII 2.00	XIX 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.					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 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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. 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		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, 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)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
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 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
				1.00	
Long Term Care Hospital PPS					
80.00	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.			Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.	Y			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
				1.00	2.00
				3.00	4.00
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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	25,000	0	0	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.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				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	Y	Y	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/24/2013 2:54 pm			
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00	
								1.00		
		Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

		Y/N	Date	
		1.00	2.00	
<p>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</p> <p>COMPLETED BY ALL HOSPITALS</p> <p>Provider Organization and Operation</p>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/25/2013
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y	Attachment A	
		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.		Exhibit 2	Y
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
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/13/2013	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.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
	0	1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		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	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	PAUL	TRACZEK	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586619	PTRACZEK@WIPFLI.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/13/2013 <i>Attachments B-E</i>	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA / SENIOR MANAGER		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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-2
Part V
Date/Time Prepared:
2/24/2013 2:54 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	PAUL	1.00
2.00	Last Name	TRACZEK	2.00
3.00	Title	CPA	3.00
4.00	Employer	WIPFLI LLP	4.00
5.00	Phone Number	(715)858-6619	5.00
6.00	E-mail Address	PTRACZEK@WIPFLI.COM	6.00
7.00	Department	HEALTHCARE	7.00
8.00	Mailing Address 1	3703 OAKWOOD HILLS PKWY / PO BOX 690	8.00
9.00	Mailing Address 2		9.00
10.00	City	EAU CLAIRE	10.00
11.00	State	WI	11.00
12.00	Zip	54701	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	TRACY	13.00
14.00	Last Name	BAUER	14.00
15.00	Title	CHIEF EXECUTIVE OFFICER	15.00
16.00	Employer	MIDWEST MEDICAL CENTER	16.00
17.00	Phone Number	(815)776-7266	17.00
18.00	E-mail Address	TBAUER@GALENAHEALTH.ORG	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	ONE MEDICAL CENTER DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	GALENA	22.00
23.00	State	IL	23.00
24.00	Zip	61036	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	12,672.00	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					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	12,672.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,150	12,672.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,830		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE	46.00	52	19,032		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				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		82			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	423	41	528	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF Subprovider		0	0		3.00	
4.00 HMO IRF Subprovider		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	1,212	0	1,212	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	139	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,635	41	1,879	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	1,635	41	1,879	14.00	
15.00 CAH visits	0	4,768	0	19,081	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF	0	0	0	0	17.00	
18.00 SUBPROVIDER	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY	0	344	0	381	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE				17,799	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	25.10	
26.00 RURAL HEALTH CLINIC	0	2,017	0	9,763	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	129	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges		1.00
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	168	1.00
2.00 HMO					0	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	92.25	0.00	0	168	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00	3.31	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	48.67	0.00			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	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	13.25	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	157.48	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	13	218	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			5.00
6.00 Hospital Adults & Peds. Swing Bed NF			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)			7.00
8.00 INTENSIVE CARE UNIT			8.00
9.00 CORONARY CARE UNIT			9.00
10.00 BURN INTENSIVE CARE UNIT			10.00
11.00 SURGICAL INTENSIVE CARE UNIT			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)			12.00
13.00 NURSERY			13.00
14.00 Total (see instructions)	13	218	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF	0	0	17.00
18.00 SUBPROVIDER	0	0	18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE		58	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			25.10
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/24/2013 2:54 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.	N			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	02/01/2000		2.00	
		Group	SNF Days	Swing Bed Days	SNF	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00	4.00
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	9	0	0	9 17.00
18.00		RHC	0	0	0	0 18.00
19.00		RHB	13	0	0	13 19.00
20.00		RHA	76	0	0	76 20.00
21.00		RMC	11	0	0	11 21.00
22.00		RMB	82	0	0	82 22.00
23.00		RMA	71	0	0	71 23.00
24.00		RLB	15	0	0	15 24.00
25.00		RLA	0	0	0	0 25.00
26.00		ES3	0	0	0	0 26.00
27.00		ES2	0	0	0	0 27.00
28.00		ES1	0	0	0	0 28.00
29.00		HE2	0	0	0	0 29.00
30.00		HE1	0	0	0	0 30.00
31.00		HD2	0	0	0	0 31.00
32.00		HD1	0	0	0	0 32.00
33.00		HC2	0	0	0	0 33.00
34.00		HC1	0	0	0	0 34.00
35.00		HB2	0	0	0	0 35.00
36.00		HB1	22	0	0	22 36.00
37.00		LE2	0	0	0	0 37.00
38.00		LE1	0	0	0	0 38.00
39.00		LD2	0	0	0	0 39.00
40.00		LD1	0	0	0	0 40.00
41.00		LC2	0	0	0	0 41.00
42.00		LC1	0	0	0	0 42.00
43.00		LB2	0	0	0	0 43.00
44.00		LB1	0	0	0	0 44.00
45.00		CE2	0	0	0	0 45.00
46.00		CE1	0	0	0	0 46.00
47.00		CD2	0	0	0	0 47.00
48.00		CD1	0	0	0	0 48.00
49.00		CC2	0	0	0	0 49.00
50.00		CC1	15	0	0	15 50.00
51.00		CB2	0	0	0	0 51.00
52.00		CB1	0	0	0	0 52.00
53.00		CA2	0	0	0	0 53.00
54.00		CA1	0	0	0	0 54.00
55.00		SE3	0	0	0	0 55.00
56.00		SE2	0	0	0	0 56.00
57.00		SE1	0	0	0	0 57.00
58.00		SSC	0	0	0	0 58.00
59.00		SSB	0	0	0	0 59.00
60.00		SSA	0	0	0	0 60.00
61.00		IB2	0	0	0	0 61.00
62.00		IB1	0	0	0	0 62.00
63.00		IA2	0	0	0	0 63.00
64.00		IA1	0	0	0	0 64.00
65.00		BB2	0	0	0	0 65.00
66.00		BB1	0	0	0	0 66.00
67.00		BA2	0	0	0	0 67.00
68.00		BA1	0	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provider CCN: 141302		Period: From 10/01/2011 To 09/30/2012	Worksheet S-7 Date/Time Prepared: 2/24/2013 2:54 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	25	0	25	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	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		344	0	344	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

SNF SERVICES				
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	0	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	1,142,615	792.08	N	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)	144,255			207.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7
Date/Time Prepared:
2/24/2013 2:54 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.	N			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	02/01/2000		2.00
		Group	SNF Days	Swing Bed Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	9	0	9 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	13	0	13 19.00
20.00		RHA	76	0	76 20.00
21.00		RMC	11	0	11 21.00
22.00		RMB	82	0	82 22.00
23.00		RMA	71	0	71 23.00
24.00		RLB	15	0	15 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	22	0	22 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	15	0	15 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-7

Date/Time Prepared:
2/24/2013 2:54 pm

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
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	25	0	25	73.00
74.00	PC1	0	0	0	74.00
75.00	PB2	0	0	0	75.00
76.00	PB1	5	0	5	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	344	0	344	200.00

	CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
			1.00
201.00	99914	0	201.00

SNF SERVICES

201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).

	Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?		
				1.00	2.00
202.00	Staffing	1,142,615	792.08	N	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)	144,255			207.00

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)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/24/2013 2:54 pm		
			Rural Health Clinic (RHC) I	Cost		
		County				
		4.00				
2.00	City, State, Zip Code, County	JO DAVIESS		2.00		
		Tuesday		wednesday		
		from	to	from	to	
		5.00	6.00	7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

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

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2011
To 09/30/2012

Worksheet S-8
Date/Time Prepared:
2/24/2013 2:54 pm

				Rural Health Clinic (RHC) I		Cost
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

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

Provider CCN: 141302
 Component CCN: 148511

Period:
 From 10/01/2011
 To 09/30/2012

Worksheet 5-8
 Date/Time Prepared:
 2/24/2013 2:54 pm

		Rural Health Clinic (RHC) I	Cost
--	--	--------------------------------	------

		Saturday		
		from	to	
		13.00	14.00	

11.00	Facility hours of operations (1) Clinic	08:00	12:00	11.00
-------	--	-------	-------	-------

		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)	0.886459	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,414,444	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,723,137	6.00
7.00	Medicaid cost (line 1 times line 6)	3,300,408	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,885,964	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)	1,885,964	19.00
		uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	
		3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	100,550	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	89,133	0
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	89,133	0
		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)	873,702	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	28,956	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	844,746	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	748,833	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	837,966	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,723,930	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,762,045	1,762,045	-1,642,469	119,576	1.00
1.01	00101		0	0	114,258	114,258	1.01
1.02	00102		0	0	4,290,667	4,290,667	1.02
1.03	00103		0	0	0	0	1.03
2.00	00200		849,424	849,424	-758,681	90,743	2.00
2.01	00201		0	0	1,169,851	1,169,851	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400	0	1,435,556	1,435,556	-98,376	1,337,180	4.00
5.01	00510	179,541	7,108	186,649	0	186,649	5.01
5.02	00560	500,951	1,298,307	1,799,258	-280,746	1,518,512	5.02
6.00	00600	0	0	0	0	0	6.00
7.00	00700	47,535	583,581	631,116	-71,021	560,095	7.00
7.01	00701	66,770	75,521	142,291	71,021	213,312	7.01
8.00	00800	0	91,245	91,245	-36,359	54,886	8.00
8.01	00801	0	0	0	36,359	36,359	8.01
9.00	00900	105,873	234	106,107	0	106,107	9.00
9.01	00901	83,105	205	83,310	0	83,310	9.01
10.00	01000	164,251	91,171	255,422	0	255,422	10.00
10.01	01001	202,080	211,790	413,870	104,792	518,662	10.01
11.00	01100	0	0	0	0	0	11.00
11.01	01101	0	0	0	0	0	11.01
13.00	01300	141,179	238	141,417	36,499	177,916	13.00
15.00	01500	0	0	0	114,524	114,524	15.00
16.00	01600	99,884	5,848	105,732	42,036	147,768	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	518,574	52,161	570,735	96,840	667,575	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	51,539	51,539	44.00
46.00	04600	1,142,615	146,548	1,289,163	120,802	1,409,965	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	120,715	136,491	257,206	23,182	280,388	50.00
53.00	05300	0	73,943	73,943	0	73,943	53.00
54.00	05400	268,162	733,222	1,001,384	0	1,001,384	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	246,985	346,218	593,203	0	593,203	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	28,040	28,040	0	28,040	64.00
65.00	06500	19,273	20,784	40,057	0	40,057	65.00
66.00	06600	523,792	88,106	611,898	-26,154	585,744	66.00
67.00	06700	0	68,667	68,667	12,097	80,764	67.00
68.00	06800	0	5,951	5,951	0	5,951	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	59,239	76,826	136,065	0	136,065	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	323,916	323,916	-101,304	222,612	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	13,415	13,415	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,218,059	177,471	1,395,530	-60,658	1,334,872	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	271,134	1,189,101	1,460,235	0	1,460,235	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							
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	3,105,833	3,105,833	-3,069,669	36,164	113.00
118.00		5,979,717	12,985,551	18,965,268	152,445	19,117,713	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	69,087	69,087	-56,125	12,962	192.00
192.01	19201	0	0	0	0	0	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	206,229	133,428	339,657	-88,686	250,971	194.01
194.02	07952 ADULT DAY CARE	106,227	58,397	164,624	-21,691	142,933	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	7,254	7,254	0	7,254	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	14,057	14,057	194.05
200.00	TOTAL (SUM OF LINES 118-199)	6,292,173	13,253,717	19,545,890	0	19,545,890	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	119,576	1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG	0	114,258	1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL	-152,426	4,138,241	1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-1,814	88,929	2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-30,267	1,139,584	2.01
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	0	1,337,180	4.00
5.01	00510 ADMITTING	0	186,649	5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	-116,306	1,402,206	5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	-5,785	554,310	7.00
7.01	00701 OPERATION OF PLANT-SCC	0	213,312	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	54,886	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	36,359	8.01
9.00	00900 HOUSEKEEPING	0	106,107	9.00
9.01	00901 HOUSEKEEPING-SCC	0	83,310	9.01
10.00	01000 DIETARY	0	255,422	10.00
10.01	01001 DIETARY-SCC	-104,792	413,870	10.01
11.00	01100 CAFETERIA	-65,122	-65,122	11.00
11.01	01101 CAFETERIA-SCC	-57,770	-57,770	11.01
13.00	01300 NURSING ADMINISTRATION	0	177,916	13.00
15.00	01500 PHARMACY	0	114,524	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2,002	145,766	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-9,111	658,464	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	51,539	44.00
46.00	04600 OTHER LONG TERM CARE	-45,228	1,364,737	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-65,351	215,037	50.00
53.00	05300 ANESTHESIOLOGY	0	73,943	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-241,586	759,798	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	593,203	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	28,040	64.00
65.00	06500 RESPIRATORY THERAPY	0	40,057	65.00
66.00	06600 PHYSICAL THERAPY	0	585,744	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	80,764	67.00
68.00	06800 SPEECH PATHOLOGY	0	5,951	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	136,065	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	222,612	73.00
76.00	03020 SLEEP LAB	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	13,415	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-8,755	1,326,117	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	-245,015	1,215,220	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
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	-36,164	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,187,494	17,930,219	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	12,962	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	250,971	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
194.02	07952	ADULT DAY CARE	0	142,933	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	7,254	194.03
194.04	07954	IDLE SPACE	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	14,057	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,187,494	18,358,396	200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	DIETARY-SCC		10.01	0	104,792	1.00
2.00			0.00	0	0	2.00
	TOTALS			0	104,792	
C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-ALU BLDG		1.01	0	111,798	1.00
	TOTALS			0	111,798	
D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	12,738	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	43,387	2.00
	TOTALS			0	56,125	
E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	SKILLED NURSING FACILITY		44.00	0	18,390	1.00
2.00	OTHER LONG TERM CARE		46.00	0	191,261	2.00
	TOTALS			0	209,651	
F - RECLASS PHARMACIST EXPENSE						
1.00	PHARMACY		15.00	0	114,524	1.00
	TOTALS			0	114,524	
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	ADULTS & PEDIATRICS		30.00	8,843	884	1.00
	TOTALS			8,843	884	
H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	1,567,099	1.00
	TOTALS			0	1,567,099	
I - RECLASS NEW HOSPITAL BOND AMORTIZATN						
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	24,071	1.00
	TOTALS			0	24,071	
J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	0	761,688	1.00
	TOTALS			0	761,688	
K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	NEW CAP REL COSTS-2007 HOSPITAL		1.02	0	2,666,877	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	0	402,792	2.00
	TOTALS			0	3,069,669	
L - RECLASS SENIOR CARE CAMPUS UTILITIES						
1.00	OPERATION OF PLANT-SCC		7.01	0	71,021	1.00
	TOTALS			0	71,021	
M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	ADULTS & PEDIATRICS		30.00	7,924	1,189	1.00
	TOTALS			7,924	1,189	
P - RECLASS PHYSICIAN BENEFITS						
1.00	RURAL HEALTH CLINIC		88.00	0	52,303	1.00
2.00	RURAL HEALTH CLINIC		88.00	0	46,073	2.00
	TOTALS			0	98,376	
S - RECLASS CHIEF MED DIRECTOR FEES						
1.00			0.00	0	0	1.00
	TOTALS			0	0	
T - RECLASS RHC COSTS AFTER CERTIFICATN						
1.00			0.00	0	0	1.00
	TOTALS			0	0	
U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	COMMUNITY FITNESS CENTER		194.05	9,404	4,653	1.00
2.00	OCCUPATIONAL THERAPY		67.00	10,756	1,341	2.00
	TOTALS			20,160	5,994	
V - RECLASS MEDICARE CERTIFIED SNF UNIT						
1.00	SKILLED NURSING FACILITY		44.00	23,946	7,541	1.00
	TOTALS			23,946	7,541	
X - RECLASS SURGEON FEES						
1.00	RURAL HEALTH CLINIC		88.00	0	49,818	1.00
2.00	OPERATING ROOM		50.00	0	23,182	2.00
	TOTALS			0	73,000	
Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER CAPITAL RELATED COSTS		3.00	0	47,832	1.00
	TOTALS			0	47,832	

RECLASSIFICATIONS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-6

Date/Time Prepared:
2/24/2013 2:54 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
Z - RECLASS CMO CONTRACTED FEES FROM SAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	19,924	1.00	
	TOTALS		0	19,924		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	OTHER LONG TERM CARE	46.00	287	0	1.00	
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	2,226	0	2.00	
	TOTALS		2,513	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	SKILLED NURSING FACILITY	44.00	1,662	0	1.00	
2.00	ASSISTED LIVING UNITS	194.01	7,252	0	2.00	
3.00	ADULT DAY CARE	194.02	3,710	0	3.00	
	TOTALS		12,624	0		
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE						
1.00		0.00	0	0	1.00	
	TOTALS		0	0		
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	NURSING ADMINISTRATION	13.00	35,415	1,084	1.00	
	TOTALS		35,415	1,084		
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC	8.01	0	36,359	1.00	
	TOTALS		0	36,359		
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,220	1.00	
2.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	13,415	0	2.00	
	TOTALS		13,415	13,220		
GG - RECLASS OUTSOURCE BILLING FEES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	16,547	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	16,547		
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	ADULTS & PEDIATRICS	30.00	78,000	0	1.00	
	TOTALS		78,000	0		
II - RECLASS MEDICAL RECORD SALARIES						
1.00	MEDICAL RECORDS & LIBRARY	16.00	42,036	0	1.00	
	TOTALS		42,036	0		
500.00	Grand Total: Increases		244,876	6,412,388	500.00	

		Decreases			wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	ADULT DAY CARE	194.02	0	17,127	0	1.00
2.00	ASSISTED LIVING UNITS	194.01	0	87,665	0	2.00
	TOTALS		0	104,792		
C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	111,798	9	1.00
	TOTALS		0	111,798		
D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,738	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,387	9	2.00
	TOTALS		0	56,125		
E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	209,651	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	209,651		
F - RECLASS PHARMACIST EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	114,524	0	1.00
	TOTALS		0	114,524		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	RURAL HEALTH CLINIC	88.00	8,843	884	0	1.00
	TOTALS		8,843	884		
H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,567,099	9	1.00
	TOTALS		0	1,567,099		
I - RECLASS NEW HOSPITAL BOND AMORTIZATN						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,071	9	1.00
	TOTALS		0	24,071		
J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	761,688	9	1.00
	TOTALS		0	761,688		
K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	INTEREST EXPENSE	113.00	0	3,069,669	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	3,069,669		
L - RECLASS SENIOR CARE CAMPUS UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	71,021	0	1.00
	TOTALS		0	71,021		
M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	RURAL HEALTH CLINIC	88.00	7,924	1,189	0	1.00
	TOTALS		7,924	1,189		
P - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	98,376	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	98,376		
S - RECLASS CHIEF MED DIRECTOR FEES						
1.00		0.00	0	0	0	1.00
	TOTALS		0	0		
T - RECLASS RHC COSTS AFTER CERTIFICATN						
1.00		0.00	0	0	0	1.00
	TOTALS		0	0		
U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	PHYSICAL THERAPY	66.00	20,160	5,994	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		20,160	5,994		
V - RECLASS MEDICARE CERTIFIED SNF UNIT						
1.00	OTHER LONG TERM CARE	46.00	23,946	7,541	0	1.00
	TOTALS		23,946	7,541		
X - RECLASS SURGEON FEES						
1.00	RURAL HEALTH CLINIC	88.00	73,000	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		73,000	0		
Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	47,832	12	1.00
	TOTALS		0	47,832		
Z - RECLASS CMO CONTRACTED FEES FROM SAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	19,924	0	0	1.00
	TOTALS		19,924	0		

		Decreases				wkst. A-7 Ref.	
Cost Center		Line #	Salary	Other			
6.00		7.00	8.00	9.00	10.00		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC	88.00	2,513	0	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			2,513	0			
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE	46.00	12,624	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			12,624	0			
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE							
1.00		0.00	0	0	0		1.00
TOTALS			0	0			
DD - RECLASS NURSE PRACTITIONER MGMT TIME							
1.00	RURAL HEALTH CLINIC	88.00	35,415	1,084	0		1.00
TOTALS			35,415	1,084			
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	36,359	0		1.00
TOTALS			0	36,359			
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE	46.00	13,415	13,220	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			13,415	13,220			
GG - RECLASS OUTSOURCE BILLING FEES							
1.00	ASSISTED LIVING UNITS	194.01	0	8,273	0		1.00
2.00	ADULT DAY CARE	194.02	0	8,274	0		2.00
TOTALS			0	16,547			
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC	88.00	78,000	0	0		1.00
TOTALS			78,000	0			
II - RECLASS MEDICAL RECORD SALARIES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	42,036	0	0		1.00
TOTALS			42,036	0			
500.00	Grand Total: Decreases		337,800	6,319,464			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/24/2013 2:54 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	559,916	0	0	0	1.00
2.00	Land Improvements	3,708,516	4,800	0	4,800	2.00
3.00	Buildings and Fixtures	38,978,344	241,832	0	241,832	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	9,028,005	286,432	0	286,432	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,274,781	533,064	0	533,064	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,274,781	533,064	0	533,064	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	1,762,045	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	849,424	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,611,469	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,749,673	0	4,749,673	0.091443	4,374
1.01	NEW CAP REL COSTS-ALU BLDG	2,671,550	0	2,671,550	0.051434	2,460
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,422,982	0	35,422,982	0.681976	32,620
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,265,141	0	3,265,141	0.062862	3,007
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	5,832,247	0	5,832,247	0.112285	5,371
3.00	Total (sum of lines 1-2)	51,941,593	0	51,941,593	1.000000	47,832

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/24/2013 2:54 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	559,916	0				1.00
2.00	Land Improvements	3,713,316	0				2.00
3.00	Buildings and Fixtures	39,130,890	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,097,387	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	52,501,509	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	52,501,509	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	1,762,045				1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0				1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	849,424				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,611,469				3.00
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	4,374	115,202	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,460	111,798	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	32,620	1,591,170	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	3,007	85,922	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	5,371	753,500	0	2.01
3.00	Total (sum of lines 1-2)	0	0	47,832	2,657,592	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/24/2013 2:54 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	0	4,374	0	0	119,576	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,460	0	0	114,258	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	2,514,451	32,620	0	0	4,138,241	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,007	0	0	88,929	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	380,713	5,371	0	0	1,139,584	2.01
3.00	Total (sum of lines 1-2)	2,895,164	47,832	0	0	5,600,588	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8

Date/Time Prepared:
2/24/2013 2:54 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)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			0	NEW CAP REL COSTS-ALU BLDG	1.01	1.01
1.02 Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)			0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	1.02
1.03 Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			0	NEW CAP REL COSTS-2007 MOB	1.03	1.03
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-116	0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	2.01
3.00 Investment income - other (chapter 2)	B	-768	0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	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)	B	-5,785	0	OPERATION OF PLANT	7.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	7.00
8.00 Television and radio service (chapter 21)			0		0.00	8.00
9.00 Parking lot (chapter 21)			0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-561,063	0			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0	0			12.00
13.00 Laundry and linen service			0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-65,122	0	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			0		0.00	17.00
18.00 Sale of medical records and abstracts	B	-2,002	0	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	19.00
20.00 vending machines			0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A	-36,164	0	INTEREST EXPENSE	113.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - NEW CAP REL COSTS-ALU BLDG			0	NEW CAP REL COSTS-ALU BLDG	1.01	26.01
26.02 Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	26.02
26.03 Depreciation - NEW CAP REL COSTS-2007 MOB			0	NEW CAP REL COSTS-2007 MOB	1.03	26.03
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	27.01
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	33.00
33.01 AR INSURANCE INTEREST INCOME	B	-8,314	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	33.01
33.05 DISALLOW PT BUYOUT AMORTIZATION EXP	A	-6,240	0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	33.05

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
33.06 PART B BILLING COSTS	A	-15,123	OTHER ADMINISTRATIVE AND GENERAL	5.02 33.06
33.07 PATIENT PHONE DEPRECIATION	A	-1,814	NEW CAP REL COSTS-MVBLE EQUIP	2.00 33.07
33.08 PATIENT TELEVISION DEPRECIATION	A	-8,188	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01 33.08
33.09 MARKETING EXPENSES - NONALLOW	A	-55,279	OTHER ADMINISTRATIVE AND GENERAL	5.02 33.09
34.00 LOBBYING EXPENSE ON DUES PAID	A	-6,808	OTHER ADMINISTRATIVE AND GENERAL	5.02 34.00
35.00 COMMUNITY GRANTS / DONATIONS / PROM	A	-12,265	OTHER ADMINISTRATIVE AND GENERAL	5.02 35.00
36.00 NH BED ASSESSMENT	A	-45,228	OTHER LONG TERM CARE	46.00 36.00
37.00 UNNECESSARY BORROWING ADJ - NEW HOSP	A	-145,418	NEW CAP REL COSTS-2007 HOSPITAL	1.02 37.00
38.00 UNNECESSARY BORROWING ADJ - NEW MME	A	-21,963	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01 38.00
40.00 SENIOR CARE CAMPUS CAFETERIA	B	-57,770	CAFETERIA-SCC	11.01 40.00
41.00 OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-104,792	DIETARY-SCC	10.01 41.00
42.00 RHC PROVIDER OR TIME	A	-8,755	RURAL HEALTH CLINIC	88.00 42.00
43.00 PENALTY PAID ON NH BED ASSESS/IRS FE	A	-18,517	OTHER ADMINISTRATIVE AND GENERAL	5.02 43.00
44.00		0		0.00 44.00
45.00		0		0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,187,494		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

worksheet A-8

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)	0	1.01
1.02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	0	1.02
1.03	Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	11	2.01
3.00	Investment income - other (chapter 2)	11	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
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	27.01
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
33.01	AR INSURANCE INTEREST INCOME	0	33.01
33.05	DISALLOW PT BUYOUT AMORTIZATION EXP	11	33.05
33.06	PART B BILLING COSTS	0	33.06
33.07	PATIENT PHONE DEPRECIATION	9	33.07
33.08	PATIENT TELEVISION DEPRECIATION	9	33.08
33.09	MARKETING EXPENSES - NONALLOW	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	0	35.00
36.00	NH BED ASSESSMENT	0	36.00
37.00	UNNECESSARY BORROWING ADJ - NEW HOSP	11	37.00
38.00	UNNECESSARY BORROWING ADJ - NEW MME	11	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	0	41.00

Provider CCN: 141302

Period:
 From 10/01/2011
 To 09/30/2012

Worksheet A-8

Date/Time Prepared:
 2/24/2013 2:54 pm

Cost Center Description		Wkst. A-7	Ref.	
		5.00		
42.00	RHC PROVIDER OR TIME		0	42.00
43.00	PENALTY PAID ON NH BED ASSESS/IRS FE		0	43.00
44.00			0	44.00
45.00			0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		0	50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/24/2013 2:54 pm

	wkst. A Line #	Cost Center/Physician Identifier	Total	Professional	
			Remuneration	Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	1,063,434	245,015	1.00
2.00	60.00	LABORATORY	19,388	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	241,587	241,586	3.00
4.00	30.00	ADULTS & PEDIATRICS	9,112	9,111	4.00
5.00	50.00	OPERATING ROOM	65,352	65,351	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,398,873	561,063	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/24/2013 2:54 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	818,419	0	0	0	0	1.00
2.00	19,388	0	0	0	0	2.00
3.00	1	0	0	0	0	3.00
4.00	1	0	0	0	0	4.00
5.00	1	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	837,810					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:
2/24/2013 2:54 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet A-8-2
Date/Time Prepared:
2/24/2013 2:54 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	245,015	1.00
2.00	0	0	2.00
3.00	0	241,586	3.00
4.00	0	9,111	4.00
5.00	0	65,351	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	561,063	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302		Period: From 10/01/2011 To 09/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					8	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	43.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.62	38.62	0.00			11.00
12.00	Number of travel hours (provider site)	0	2	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					3,321	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					3,321	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					3,321	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.23	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					4,634	22.00
23.00	Total salary equivalency (see instructions)					4,634	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					309	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					309	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					44	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					353	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					154	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					154	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					353	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm
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					Physical Therapy	Cost
						1.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0 46.00
		Therapists	Assistants	Aides	Trainees	Total
		1.00	2.00	3.00	4.00	5.00

PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00 47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00 50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00 51.00
DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.24	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0 56.00
						1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57.00	Salary equivalency amount (from line 23)					4,634 57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					353 58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0 59.00
60.00	Overtime allowance (from column 5, line 56)					0 60.00
61.00	Equipment cost (see instructions)					0 61.00
62.00	Supplies (see instructions)					0 62.00
63.00	Total allowance (sum of lines 57-62)					4,987 63.00
64.00	Total cost of outside supplier services (from your records)					3,267 64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0 65.00
LINE 33 CALCULATION						
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					309 100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					44 100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					353 100.02
LINE 34 CALCULATION						
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					44 101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					154 101.01
101.02	Line 34 = sum of lines 27 and 31					198 101.02
LINE 35 CALCULATION						
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					154 102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0 102.01
102.02	Line 35 = sum of lines 31 and 32					154 102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm		
			Occupational Therapy	Cost		
				1.00		
PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00	
2.00	Line 1 multiplied by 15 hours per week			780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			208	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			5.50	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	673.36	0.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	72.85	0.00	0.00	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.43	36.43	0.00		
12.00	Number of travel hours (provider site)	0	575	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
				1.00		
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			49,054	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			49,054	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			49,054	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			72.85	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			56,823	22.00	
23.00	Total salary equivalency (see instructions)			56,823	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)			7,577	24.00	
25.00	Assistants (line 4 times column 3, line 11)			0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			7,577	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			1,144	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			8,721	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			41,889	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			41,889	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			8,721	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302		Period: From 10/01/2011 To 09/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm	
						Occupational Therapy	Cost
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.85	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					56,823	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					8,721	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					65,544	63.00
64.00	Total cost of outside supplier services (from your records)					37,035	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					7,577	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,144	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					8,721	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,144	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					41,889	101.01
101.02	Line 34 = sum of lines 27 and 31					43,033	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					41,889	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					41,889	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY		Provider CCN: 141302		Period: From 10/01/2011 To 09/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm		
OUTSIDE SUPPLIERS				Speech Pathology		Cost		
								1.00
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					24	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					0.51	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	125.65	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	67.23	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.62	33.62	0.00			11.00	
12.00	Number of travel hours (provider site)	0	15	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
								1.00
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,447	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					8,447	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					8,447	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.23	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,439	22.00	
23.00	Total salary equivalency (see instructions)					52,439	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					807	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					807	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					12	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					819	28.00	
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					1,008	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					1,008	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					819	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2013 2:54 pm
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		Speech Pathology				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.23	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					52,439	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					819	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					53,258	63.00
64.00	Total cost of outside supplier services (from your records)					5,950	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					807	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					12	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					819	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					12	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					1,008	101.01
101.02	Line 34 = sum of lines 27 and 31					1,020	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					1,008	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					1,008	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	119,576	119,576			1.00
1.01 00101	NEW CAP REL COSTS-ALU BLDG	114,258	0	114,258		1.01
1.02 00102	NEW CAP REL COSTS-2007 HOSPITAL	4,138,241	0	0	4,138,241	1.02
1.03 00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	88,929				2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	1,139,584				2.01
4.00 00400	EMPLOYEE BENEFITS	1,337,180	0	0	0	4.00
5.01 00510	ADMITTING	186,649	0	0	59,811	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	1,402,206	19,134	34,352	388,651	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	554,310	0	0	278,353	7.00
7.01 00701	OPERATION OF PLANT-SCC	213,312	4,556	0	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	54,886	0	0	28,128	8.00
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	36,359	456	0	0	8.01
9.00 00900	HOUSEKEEPING	106,107	0	0	21,333	9.00
9.01 00901	HOUSEKEEPING-SCC	83,310	867	0	0	9.01
10.00 01000	DIETARY	255,422	0	0	99,632	10.00
10.01 01001	DIETARY-SCC	413,870	3,368	0	0	10.01
11.00 01100	CAFETERIA	-65,122	0	0	153,675	11.00
11.01 01101	CAFETERIA-SCC	-57,770	0	0	0	11.01
13.00 01300	NURSING ADMINISTRATION	177,916	1,510	0	10,113	13.00
15.00 01500	PHARMACY	114,524	0	0	61,075	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	145,766	0	0	54,280	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	658,464	0	0	707,142	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
44.00 04400	SKILLED NURSING FACILITY	51,539	3,953	0	0	44.00
46.00 04600	OTHER LONG TERM CARE	1,364,737	41,119	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	215,037	0	0	425,391	50.00
53.00 05300	ANESTHESIOLOGY	73,943	0	0	4,267	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	759,798	0	0	286,886	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	593,203	0	0	85,015	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	28,040	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	40,057	0	0	14,854	65.00
66.00 06600	PHYSICAL THERAPY	585,744	0	0	369,373	66.00
67.00 06700	OCCUPATIONAL THERAPY	80,764	0	0	29,392	67.00
68.00 06800	SPEECH PATHOLOGY	5,951	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,065	0	0	53,885	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	222,612	0	0	0	73.00
76.00 03020	SLEEP LAB	0	0	0	0	76.00
76.01 03021	PAIN CLINIC	0	0	0	0	76.01
76.02 03530	SNF PHYSICAL THERAPY - SCC THERAPY	13,415	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,326,117	0	0	520,124	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,215,220	0	0	437,796	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
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)	17,930,219	74,963	34,352	4,089,176	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,466	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			NEW 2007 MOB	
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		
		1.00	1.01	1.02		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	12,962	0	0	0	0	192.00
192.01 19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951 ASSISTED LIVING UNITS	250,971	0	73,923	0	0	194.01
194.02 07952 ADULT DAY CARE	142,933	0	5,983	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	7,254	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	44,613	0	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	14,057	0	0	25,599	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	18,358,396	119,576	114,258	4,138,241	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	Subtotal	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02 00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03 00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	88,929				2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	1,139,584			2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	1,337,180		4.00
5.01 00510	ADMITTING	0	0	44,505	290,965	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	9,989	116,958	109,371	0	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	30,879	11,783	0	7.00
7.01 00701	OPERATION OF PLANT-SCC	6,926	0	16,551	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	694	0	0	8.00
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	8.01
9.00 00900	HOUSEKEEPING	0	4,359	26,244	0	9.00
9.01 00901	HOUSEKEEPING-SCC	0	0	20,600	0	9.01
10.00 01000	DIETARY	0	33,268	40,715	0	10.00
10.01 01001	DIETARY-SCC	2,706	0	50,092	0	10.01
11.00 01100	CAFETERIA	0	7,571	0	0	11.00
11.01 01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00 01300	NURSING ADMINISTRATION	8,048	0	43,775	0	13.00
15.00 01500	PHARMACY	1,002	4,787	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	412	231	35,180	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,386	135,577	128,546	25,530	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
44.00 04400	SKILLED NURSING FACILITY	1,243	0	6,348	0	44.00
46.00 04600	OTHER LONG TERM CARE	12,933	0	270,920	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	885	199,150	29,923	22,759	50.00
53.00 05300	ANESTHESIOLOGY	0	28,501	0	3,493	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,301	496,903	66,473	74,098	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	1,250	6,754	61,224	59,286	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	13,211	64.00
65.00 06500	RESPIRATORY THERAPY	0	1,034	4,777	6,469	65.00
66.00 06600	PHYSICAL THERAPY	3,752	18,732	124,842	38,322	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	2,666	3,042	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	86	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	696	0	14,684	4,918	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,308	73.00
76.00 03020	SLEEP LAB	0	0	0	0	76.00
76.01 03021	PAIN CLINIC	0	0	0	0	76.01
76.02 03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	3,325	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	166	29,702	74,924	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	3,512	23,094	67,210	19,443	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
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)	83,207	1,138,194	1,254,678	290,965	17,667,021
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	194	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	Subtotal	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01	4.00	5.01	5A.01	
194.01 07951 ASSISTED LIVING UNITS	3,945	0	52,919	0	381,758	194.01
194.02 07952 ADULT DAY CARE	1,538	0	27,252	0	177,706	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	7,254	194.03
194.04 07954 IDLE SPACE	0	0	0	0	44,613	194.04
194.05 07955 COMMUNITY FITNESS CENTER	239	1,196	2,331	0	43,422	194.05
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	88,929	1,139,584	1,337,180	290,965	18,358,396	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
		5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	2,080,661					5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	132,650		1,007,975			7.00
7.01	00701 OPERATION OF PLANT-SCC	0	0	0	241,345		7.01
8.00	00800 LAUNDRY & LINEN SERVICE	12,685	0	8,311	0	104,704	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	761	0	8.01
9.00	00900 HOUSEKEEPING	23,950	0	6,303	0	5,143	9.00
9.01	00901 HOUSEKEEPING-SCC	0	0	0	1,447	0	9.01
10.00	01000 DIETARY	65,018	0	29,438	0	402	10.00
10.01	01001 DIETARY-SCC	0	0	0	5,625	0	10.01
11.00	01100 CAFETERIA	14,567	0	45,406	0	0	11.00
11.01	01101 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300 NURSING ADMINISTRATION	36,577	0	2,988	2,522	0	13.00
15.00	01500 PHARMACY	27,488	0	18,046	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	35,745	0	16,038	0	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	252,419	0	208,941	0	29,374	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	6,601	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	68,674	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	135,351	0	125,690	0	10,099	50.00
53.00	05300 ANESTHESIOLOGY	16,701	0	1,261	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	258,149	0	84,766	0	7,269	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	122,255	0	25,119	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	6,251	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	10,182	0	4,389	0	0	65.00
66.00	06600 PHYSICAL THERAPY	172,876	0	109,139	0	25,797	66.00
67.00	06700 OCCUPATIONAL THERAPY	17,558	0	8,684	0	2,048	67.00
68.00	06800 SPEECH PATHOLOGY	915	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	31,862	0	15,921	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	36,813	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	2,537	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	295,671	0	153,681	0	3,375	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	267,668	0	129,356	0	19,407	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	1,975,888	0	993,477	85,630	102,914	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,586	0	6,934	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,964	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	57,853	0	0	75,124	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
			5.02	6.00	7.00	7.01	8.00	
194.02	07952	ADULT DAY CARE	26,930	0	0	6,080	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	1,099	0	0	0	0	194.03
194.04	07954	IDLE SPACE	6,761	0	0	74,511	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	6,580	0	7,564	0	1,790	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,080,661	0	1,007,975	241,345	104,704	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	37,576					8.01
9.00	00900 HOUSEKEEPING	0	193,439				9.00
9.01	00901 HOUSEKEEPING-SCC	0	0	106,224			9.01
10.00	01000 DIETARY	0	6,233	0	530,128		10.00
10.01	01001 DIETARY-SCC	0	0	3,629	0	479,290	10.01
11.00	01100 CAFETERIA	0	9,613	0	365,625	0	11.00
11.01	01101 CAFETERIA-SCC	0	0	0	0	66,135	11.01
13.00	01300 NURSING ADMINISTRATION	0	633	1,627	0	0	13.00
15.00	01500 PHARMACY	0	3,821	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	3,396	0	0	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	44,236	0	164,503	0	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	3,296	0	4,260	0	5,739	44.00
46.00	04600 OTHER LONG TERM CARE	34,280	0	44,312	0	268,115	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	26,611	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	267	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,947	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	5,318	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	929	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	8,422	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	667	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	3,371	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	32,537	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	27,387	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	37,576	191,388	53,828	530,128	339,989	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,468	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	0	48,473	0	100,356	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		LAUNDRY & LINEN SERVICE-SCC 8.01	HOUSEKEEPING 9.00	HOUSEKEEPING-SCC 9.01	DIETARY 10.00	DIETARY-SCC 10.01	
194.02	07952 ADULT DAY CARE	0	0	3,923	0	38,945	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	583	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	37,576	193,439	106,224	530,128	479,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	11.01	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900 HOUSEKEEPING						9.00
9.01	00901 HOUSEKEEPING-SCC						9.01
10.00	01000 DIETARY						10.00
10.01	01001 DIETARY-SCC						10.01
11.00	01100 CAFETERIA	531,335					11.00
11.01	01101 CAFETERIA-SCC	0	8,365				11.01
13.00	01300 NURSING ADMINISTRATION	14,812	0	300,521			13.00
15.00	01500 PHARMACY	0	0	0	230,743		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	20,406	0	0	0	311,454	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	95,725	0	300,521	0	286,115	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	555	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	5,717	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	19,145	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	60,272	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	57,041	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	86,050	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,806	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	83,356	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,618	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	12,842	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	144,693	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	104,392	0	0	0	18,355	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	46,169	0	0	0	6,984	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	525,584	6,272	300,521	230,743	311,454	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	1,489	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description			CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	11.01	13.00	15.00	16.00	
194.02	07952	ADULT DAY CARE	0	604	0	0	0	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	5,751	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	531,335	8,365	300,521	230,743	311,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400 EMPLOYEE BENEFITS					4.00
5.01	00510 ADMITTING					5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600 MAINTENANCE & REPAIRS					6.00
7.00	00700 OPERATION OF PLANT					7.00
7.01	00701 OPERATION OF PLANT-SCC					7.01
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	00900 HOUSEKEEPING					9.00
9.01	00901 HOUSEKEEPING-SCC					9.01
10.00	01000 DIETARY					10.00
10.01	01001 DIETARY-SCC					10.01
11.00	01100 CAFETERIA					11.00
11.01	01101 CAFETERIA-SCC					11.01
13.00	01300 NURSING ADMINISTRATION					13.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	3,047,479	0	3,047,479	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	83,534	0	83,534	44.00
46.00	04600 OTHER LONG TERM CARE	0	2,110,807	0	2,110,807	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1,210,041	0	1,210,041	50.00
53.00	05300 ANESTHESIOLOGY	0	128,433	0	128,433	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,131,862	0	2,131,862	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	0	1,016,465	0	1,016,465	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	133,552	0	133,552	64.00
65.00	06500 RESPIRATORY THERAPY	0	87,497	0	87,497	65.00
66.00	06600 PHYSICAL THERAPY	0	1,540,355	0	1,540,355	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	151,439	0	151,439	67.00
68.00	06800 SPEECH PATHOLOGY	0	6,952	0	6,952	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	274,244	0	274,244	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	424,426	0	424,426	73.00
76.00	03020 SLEEP LAB	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	19,277	0	19,277	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	2,559,044	0	2,559,044	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	2,263,246	0	2,263,246	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
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)	0	17,188,653	0	17,188,653	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,648	0	35,648	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	14,926	0	14,926	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	665,053	0	665,053	194.01
194.02	07952	ADULT DAY CARE	0	254,188	0	254,188	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	8,353	0	8,353	194.03
194.04	07954	IDLE SPACE	0	125,885	0	125,885	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	65,690	0	65,690	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	18,358,396	0	18,358,396	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			NEW 2007 MOB
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	
	0	1.00	1.01	1.02	1.03
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01 00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02 00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03 00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0 4.00
5.01 00510	ADMITTING	0	0	59,811	0 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	19,134	34,352	388,651 0 5.02
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	0	278,353	0 7.00
7.01 00701	OPERATION OF PLANT-SCC	0	4,556	0	0 7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	28,128	0 8.00
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	0	456	0	0 8.01
9.00 00900	HOUSEKEEPING	0	0	21,333	0 9.00
9.01 00901	HOUSEKEEPING-SCC	0	867	0	0 9.01
10.00 01000	DIETARY	0	0	99,632	0 10.00
10.01 01001	DIETARY-SCC	0	3,368	0	0 10.01
11.00 01100	CAFETERIA	0	0	153,675	0 11.00
11.01 01101	CAFETERIA-SCC	0	0	0	0 11.01
13.00 01300	NURSING ADMINISTRATION	0	1,510	0	10,113 0 13.00
15.00 01500	PHARMACY	0	0	61,075	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	54,280	0 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	707,142	0 30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0 42.00
44.00 04400	SKILLED NURSING FACILITY	0	3,953	0	0 44.00
46.00 04600	OTHER LONG TERM CARE	0	41,119	0	0 46.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	425,391	0 50.00
53.00 05300	ANESTHESIOLOGY	0	0	4,267	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	286,886	0 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	0	0	85,015	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0 60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	14,854	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	369,373	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	29,392	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,885	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0 73.00
76.00 03020	SLEEP LAB	0	0	0	0 76.00
76.01 03021	PAIN CLINIC	0	0	0	0 76.01
76.02 03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	520,124	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	0	437,796	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0 92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS					
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)	0	74,963	34,352	4,089,176 0 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	23,466	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0 192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			NEW 2007 MOB	
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		
		1.00	1.01	1.02		
192.01 19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951 ASSISTED LIVING UNITS	0	0	73,923	0	0	194.01
194.02 07952 ADULT DAY CARE	0	0	5,983	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	44,613	0	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	0	0	0	25,599	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	119,576	114,258	4,138,241	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAPITAL RELATED COSTS		Subtotal 2A	EMPLOYEE BENEFITS 4.00	ADMITTING 5.01	
		NEW MVBLE EQUIP 2.00	NEW MVBLE EQUIP NEW HO 2.01				
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.01	00510	ADMITTING	0	0	59,811	0	59,811
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	9,989	116,958	569,084	0	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	0	30,879	309,232	0	0
7.01	00701	OPERATION OF PLANT-SCC	6,926	0	11,482	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	694	28,822	0	0
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	456	0	0
9.00	00900	HOUSEKEEPING	0	4,359	25,692	0	0
9.01	00901	HOUSEKEEPING-SCC	0	0	867	0	0
10.00	01000	DIETARY	0	33,268	132,900	0	0
10.01	01001	DIETARY-SCC	2,706	0	6,074	0	0
11.00	01100	CAFETERIA	0	7,571	161,246	0	0
11.01	01101	CAFETERIA-SCC	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	8,048	0	19,671	0	0
15.00	01500	PHARMACY	1,002	4,787	66,864	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	412	231	54,923	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,386	135,577	853,105	0	5,248
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	1,243	0	5,196	0	0
46.00	04600	OTHER LONG TERM CARE	12,933	0	54,052	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	885	199,150	625,426	0	4,678
53.00	05300	ANESTHESIOLOGY	0	28,501	32,768	0	718
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,301	496,903	803,090	0	15,233
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	1,250	6,754	93,019	0	12,186
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,716
65.00	06500	RESPIRATORY THERAPY	0	1,034	15,888	0	1,330
66.00	06600	PHYSICAL THERAPY	3,752	18,732	391,857	0	7,877
67.00	06700	OCCUPATIONAL THERAPY	0	0	29,392	0	625
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	18
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	696	0	54,581	0	1,011
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,174
76.00	03020	SLEEP LAB	0	0	0	0	0
76.01	03021	PAIN CLINIC	0	0	0	0	0
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	166	29,702	549,992	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	3,512	23,094	464,402	0	3,997
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
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)	83,207	1,138,194	5,419,892	0	59,811
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	194	23,660	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	CAPITAL RELATED COSTS		Subtotal 2A	EMPLOYEE BENEFITS 4.00	ADMITTING 5.01	
	NEW MVBLE EQUIP 2.00	NEW MVBLE EQUIP NEW HO 2.01				
	194.01 07951 ASSISTED LIVING UNITS	3,945				
194.02 07952 ADULT DAY CARE	1,538	0	7,521	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	0	44,613	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	239	1,196	27,034	0	0	194.05
200.00 Cross Foot Adjustments			0			200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	88,929	1,139,584	5,600,588	0	59,811	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
		5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	569,084					5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	36,281	0	345,513			7.00
7.01	00701 OPERATION OF PLANT-SCC	0	0	0	11,482		7.01
8.00	00800 LAUNDRY & LINEN SERVICE	3,470	0	2,849	0	35,141	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	36	0	8.01
9.00	00900 HOUSEKEEPING	6,551	0	2,161	0	1,726	9.00
9.01	00901 HOUSEKEEPING-SCC	0	0	0	69	0	9.01
10.00	01000 DIETARY	17,783	0	10,091	0	135	10.00
10.01	01001 DIETARY-SCC	0	0	0	268	0	10.01
11.00	01100 CAFETERIA	3,984	0	15,564	0	0	11.00
11.01	01101 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300 NURSING ADMINISTRATION	10,004	0	1,024	120	0	13.00
15.00	01500 PHARMACY	7,518	0	6,186	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9,777	0	5,498	0	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	69,039	0	71,619	0	9,859	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	314	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	3,267	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	37,020	0	43,084	0	3,389	50.00
53.00	05300 ANESTHESIOLOGY	4,568	0	432	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	70,607	0	29,056	0	2,440	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	33,438	0	8,610	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	1,710	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	2,785	0	1,504	0	0	65.00
66.00	06600 PHYSICAL THERAPY	47,284	0	37,411	0	8,658	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,802	0	2,977	0	687	67.00
68.00	06800 SPEECH PATHOLOGY	250	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	8,715	0	5,458	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,069	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	694	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	80,868	0	52,679	0	1,133	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	73,210	0	44,340	0	6,513	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	540,427	0	340,543	4,074	34,540	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	981	0	2,377	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	537	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	15,823	0	0	3,574	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
		5.02	6.00	7.00	7.01	8.00	
194.02	07952	ADULT DAY CARE	7,366	0	0	289	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	301	0	0	0	0 194.03
194.04	07954	IDLE SPACE	1,849	0	0	3,545	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	1,800	0	2,593	0	601 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	569,084	0	345,513	11,482	35,141 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	492					8.01
9.00	00900 HOUSEKEEPING		36,130				9.00
9.01	00901 HOUSEKEEPING-SCC	0	0	936			9.01
10.00	01000 DIETARY		1,164	0	162,073		10.00
10.01	01001 DIETARY-SCC		0	32	0	6,374	10.01
11.00	01100 CAFETERIA		1,796	0	111,781		11.00
11.01	01101 CAFETERIA-SCC		0	0	0	880	11.01
13.00	01300 NURSING ADMINISTRATION		118	14	0	0	13.00
15.00	01500 PHARMACY		714	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		634	0	0	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	8,262	0	50,292	0	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	43	0	38	0	76	44.00
46.00	04600 OTHER LONG TERM CARE	449	0	390	0	3,565	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	4,970	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	50	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,352	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	993	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	174	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,573	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	125	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	630	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	6,077	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	5,115	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	492	35,747	474	162,073	4,521	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	274	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	0	427	0	1,335	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
194.02	07952 ADULT DAY CARE	0	0	35	0	518	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	109	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	492	36,130	936	162,073	6,374	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	11.01	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900 HOUSEKEEPING						9.00
9.01	00901 HOUSEKEEPING-SCC						9.01
10.00	01000 DIETARY						10.00
10.01	01001 DIETARY-SCC						10.01
11.00	01100 CAFETERIA	262,231					11.00
11.01	01101 CAFETERIA-SCC	0	111				11.01
13.00	01300 NURSING ADMINISTRATION	7,310	0	38,261			13.00
15.00	01500 PHARMACY	0	0	0	81,282		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	10,071	0	0	0	80,903	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	47,244	0	38,261	0	74,321	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	7	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	76	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	9,449	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	29,746	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	28,152	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	30,312	0	64.00
65.00	06500 RESPIRATORY THERAPY	2,372	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	41,139	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,266	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	6,338	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	50,970	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	51,519	0	0	0	4,768	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	22,786	0	0	0	1,814	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	259,392	83	38,261	81,282	80,903	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	20	0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	11.01	13.00	15.00	16.00		
194.02	07952	ADULT DAY CARE	0	8	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	2,839	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	32,140	769	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	294,371	880	38,261	81,282	80,903	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400 EMPLOYEE BENEFITS					4.00
5.01	00510 ADMITTING					5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600 MAINTENANCE & REPAIRS					6.00
7.00	00700 OPERATION OF PLANT					7.00
7.01	00701 OPERATION OF PLANT-SCC					7.01
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	00900 HOUSEKEEPING					9.00
9.01	00901 HOUSEKEEPING-SCC					9.01
10.00	01000 DIETARY					10.00
10.01	01001 DIETARY-SCC					10.01
11.00	01100 CAFETERIA					11.00
11.01	01101 CAFETERIA-SCC					11.01
13.00	01300 NURSING ADMINISTRATION					13.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		1,227,250	0	1,227,250	30.00
41.00	04100 SUBPROVIDER - IRF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY		5,674	0	5,674	44.00
46.00	04600 OTHER LONG TERM CARE		61,799	0	61,799	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		728,016	0	728,016	50.00
53.00	05300 ANESTHESIOLOGY		38,536	0	38,536	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		953,524	0	953,524	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		176,398	0	176,398	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY		34,738	0	34,738	64.00
65.00	06500 RESPIRATORY THERAPY		24,053	0	24,053	65.00
66.00	06600 PHYSICAL THERAPY		535,799	0	535,799	66.00
67.00	06700 OCCUPATIONAL THERAPY		41,874	0	41,874	67.00
68.00	06800 SPEECH PATHOLOGY		268	0	268	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		76,733	0	76,733	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		65,213	0	65,213	73.00
76.00	03020 SLEEP LAB		0	0	0	76.00
76.01	03021 PAIN CLINIC		0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY		694	0	694	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		747,036	0	747,036	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		622,177	0	622,177	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
93.00	04040 FAMILY PRACTICE		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,339,782	0	5,339,782	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		27,292	0	27,292	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		537	0	537	192.00
192.01	19201 MIDWEST MEDICAL CLINIC		0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	99,047	0	99,047	194.01
194.02	07952	ADULT DAY CARE	15,737	0	15,737	194.02
194.03	07953	GRANT FUNDED PROGRAMS	301	0	301	194.03
194.04	07954	IDLE SPACE	50,007	0	50,007	194.04
194.05	07955	COMMUNITY FITNESS CENTER	34,976	0	34,976	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	32,909	0	32,909	201.00
202.00		TOTAL (sum lines 118-201)	5,600,588	0	5,600,588	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAPITAL RELATED COSTS				NEW MVBLE EQUIP (DOLLAR VALUE)		
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)			
		1.00	1.01	1.02	1.03			2.00
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					85,923	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01	00510	ADMITTING	0	0	757	0	0	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	8,147	8,900	4,919	0	9,651	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	6,692	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	1,261	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	2,615	10.01
11.00	01100	CAFETERIA	0	0	1,945	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	7,776	13.00
15.00	01500	PHARMACY	0	0	773	0	968	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	398	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	0	8,950	0	10,035	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	1,201	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	12,496	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	855	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	18,649	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	1,076	0	1,208	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,675	0	3,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	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	682	0	672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	6,583	0	160	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	3,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
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						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,918	8,900	51,755	0	80,394	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAPITAL RELATED COSTS				NEW MVBLE EQUIP (DOLLAR VALUE)		
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)			
		1.00	1.01	1.02	1.03			2.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	3,812	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	1,486	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	231	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	119,576	114,258	4,138,241	0	88,929	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	2.348588	3.859807	79.010253	0.000000	1.034985	203.00
204.00		Cost to be allocated (per wkst. B, Part II)						204.00
205.00		Unit cost multiplier (wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)		
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)						
	2.01	4.00	5.01	5A.02	5.02		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00	
1.01 00101 NEW CAP REL COSTS-ALU BLDG						1.01	
1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02	
1.03 00103 NEW CAP REL COSTS-2007 MOB						1.03	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00	
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	753,498					2.01	
4.00 00400 EMPLOYEE BENEFITS	0	5,394,374				4.00	
5.01 00510 ADMITTING	0	179,541	13,880,173			5.01	
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	77,333	441,217	0	-2,080,661	13,729,740	5.02	
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00	
7.00 00700 OPERATION OF PLANT	20,417	47,535	0	0	875,325	7.00	
7.01 00701 OPERATION OF PLANT-SCC	0	66,770	0	-241,345	0	7.01	
8.00 00800 LAUNDRY & LINEN SERVICE	459	0	0	0	83,708	8.00	
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	-36,815	0	8.01	
9.00 00900 HOUSEKEEPING	2,882	105,873	0	0	158,043	9.00	
9.01 00901 HOUSEKEEPING-SCC	0	83,105	0	-104,777	0	9.01	
10.00 01000 DIETARY	21,997	164,251	0	0	429,037	10.00	
10.01 01001 DIETARY-SCC	0	202,080	0	-470,036	0	10.01	
11.00 01100 CAFETERIA	5,006	0	0	0	96,124	11.00	
11.01 01101 CAFETERIA-SCC	0	0	0	57,770	0	11.01	
13.00 01300 NURSING ADMINISTRATION	0	176,594	0	0	241,362	13.00	
15.00 01500 PHARMACY	3,165	0	0	0	181,388	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	153	141,920	0	0	235,869	16.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	89,644	518,574	1,217,882	0	1,665,645	30.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
44.00 04400 SKILLED NURSING FACILITY	0	25,608	0	-63,083	0	44.00	
46.00 04600 OTHER LONG TERM CARE	0	1,092,917	0	-1,689,709	0	46.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	131,679	120,715	1,085,657	0	893,145	50.00	
53.00 05300 ANESTHESIOLOGY	18,845	0	166,607	0	110,204	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	328,554	268,162	3,534,983	0	1,703,459	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	4,466	246,985	2,828,136	0	806,732	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
64.00 06400 INTRAVENOUS THERAPY	0	0	630,193	0	41,251	64.00	
65.00 06500 RESPIRATORY THERAPY	684	19,273	308,584	0	67,191	65.00	
66.00 06600 PHYSICAL THERAPY	12,386	503,632	1,828,077	0	1,140,765	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	10,756	145,094	0	115,864	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	4,111	0	6,037	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,239	234,605	0	210,248	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	968,750	0	242,920	73.00	
76.00 03020 SLEEP LAB	0	0	0	0	0	76.00	
76.01 03021 PAIN CLINIC	0	0	0	0	0	76.01	
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	13,415	0	0	16,740	76.02	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	19,639	302,256	0	0	1,951,033	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	15,270	271,134	927,494	0	1,766,275	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORP	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)	752,579	5,061,552	13,880,173	-4,628,656	13,038,365	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	0	0	23,660	190.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
		2.01	4.00	5.01	5A.02	5.02	
192.00	19200	0	0	0	0	12,962	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	213,481	0	0	381,758	194.01
194.02	07952	0	109,937	0	0	177,706	194.02
194.03	07953	0	0	0	0	7,254	194.03
194.04	07954	0	0	0	0	44,613	194.04
194.05	07955	791	9,404	0	0	43,422	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,139,584	1,337,180	290,965		2,080,661	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	1.512392	0.247884	0.020963		0.151544	203.00
204.00	Cost to be allocated (per wkst. B, Part II)		0	59,811		569,084	204.00
205.00	Unit cost multiplier (wkst. B, Part II)		0.000000	0.004309		0.041449	205.00

Cost Center Description		MAINTENANCE & REPAIRS (SQURE FEET)	OPERATION OF PLANT (SQURE FT)	OPERATION OF PLANT-SCC (SQURE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
		6.00	7.00	7.01	8.00	8.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600	0					6.00
7.00	00700	0	43,177				7.00
7.01	00701	0	0	61,529			7.01
8.00	00800	0	356	0	144,334		8.00
8.01	00801	0	0	194	0	121,198	8.01
9.00	00900	0	270	0	7,089	0	9.00
9.01	00901	0	0	369	0	0	9.01
10.00	01000	0	1,261	0	554	0	10.00
10.01	01001	0	0	1,434	0	0	10.01
11.00	01100	0	1,945	0	0	0	11.00
11.01	01101	0	0	0	0	0	11.01
13.00	01300	0	128	643	0	0	13.00
15.00	01500	0	773	0	0	0	15.00
16.00	01600	0	687	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	8,950	0	40,494	0	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	1,683	0	10,631	44.00
46.00	04600	0	0	17,508	0	110,567	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,384	0	13,921	0	50.00
53.00	05300	0	54	0	0	0	53.00
54.00	05400	0	3,631	0	10,020	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	0	1,076	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	188	0	0	0	65.00
66.00	06600	0	4,675	0	35,561	0	66.00
67.00	06700	0	372	0	2,823	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	682	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	6,583	0	4,653	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	5,541	0	26,752	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							
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		0	42,556	21,831	141,867	121,198	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	297	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
			6.00	7.00	7.01	8.00	8.01	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	0 194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	19,152	0	0	0 194.01
194.02	07952	ADULT DAY CARE	0	0	1,550	0	0	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	0	18,996	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	324	0	2,467	0	0 194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,007,975	241,345	104,704	37,576	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	23.345184	3.922459	0.725429	0.310038	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	345,513	11,482	35,141	492	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	8.002247	0.186611	0.243470	0.004059	205.00

Cost Center Description		HOUSEKEEPING (SQURE FT)	HOUSEKEEPING-S CC (SQURE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
		9.00	9.01	10.00	10.01	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900	39,137					9.00
9.01	00901	0	41,970				9.01
10.00	01000	1,261	0	19,471			10.00
10.01	01001	0	1,434	0	93,039		10.01
11.00	01100	1,945	0	13,429	0	6,744	11.00
11.01	01101	0	0	0	12,838	0	11.01
13.00	01300	128	643	0	0	188	13.00
15.00	01500	773	0	0	0	0	15.00
16.00	01600	687	0	0	0	259	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,950	0	6,042	0	1,215	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	1,683	0	1,114	0	44.00
46.00	04600	0	17,508	0	52,046	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,384	0	0	0	243	50.00
53.00	05300	54	0	0	0	0	53.00
54.00	05400	3,631	0	0	0	765	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	1,076	0	0	0	724	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	188	0	0	0	61	65.00
66.00	06600	1,704	0	0	0	1,058	66.00
67.00	06700	135	0	0	0	84	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	682	0	0	0	163	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	6,583	0	0	0	1,325	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	5,541	0	0	0	586	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							
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		38,722	21,268	19,471	65,998	6,671	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	297	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-S CC (SQUARE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
		9.00	9.01	10.00	10.01	11.00	
194.01	07951 ASSISTED LIVING UNITS	0	19,152	0	19,481	0	194.01
194.02	07952 ADULT DAY CARE	0	1,550	0	7,560	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	118	0	0	0	73	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	193,439	106,224	530,128	479,290	531,335	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.942612	2.530951	27.226542	5.151496	78.786329	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	36,130	936	162,073	6,374	294,371	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.923167	0.022302	8.323815	0.068509	38.883600	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		11.01	13.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001						10.01
11.00	01100						11.00
11.01	01101	5,038					11.01
13.00	01300	0	2,919				13.00
15.00	01500	0	0	1,689,850			15.00
16.00	01600	0	0	0	5,396		16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	2,919	0	4,957		30.00
41.00	04100	0	0	0	0		41.00
42.00	04200	0	0	0	0		42.00
44.00	04400	334	0	0	0		44.00
46.00	04600	3,443	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	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	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	630,193	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	1,059,657	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	318	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	121	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							
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		3,777	2,919	1,689,850	5,396	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet B-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		11.01	13.00	15.00	16.00	19.00	
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	897	0	0	0	0	194.01
194.02	07952 ADULT DAY CARE	364	0	0	0	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	8,365	300,521	230,743	311,454	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	1.660381	102.953409	0.136546	57.719422	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	880	38,261	81,282	80,903	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.022033	13.107571	0.048100	14.993143	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,047,479		3,047,479	0	3,047,479	30.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	83,534		83,534	0	83,534	44.00
46.00	04600 OTHER LONG TERM CARE	2,110,807		2,110,807	0	2,110,807	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,210,041		1,210,041	0	1,210,041	50.00
53.00	05300 ANESTHESIOLOGY	128,433		128,433	0	128,433	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,131,862		2,131,862	0	2,131,862	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	1,016,465		1,016,465	0	1,016,465	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	133,552		133,552	0	133,552	64.00
65.00	06500 RESPIRATORY THERAPY	87,497	0	87,497	0	87,497	65.00
66.00	06600 PHYSICAL THERAPY	1,540,355	0	1,540,355	0	1,540,355	66.00
67.00	06700 OCCUPATIONAL THERAPY	151,439	0	151,439	0	151,439	67.00
68.00	06800 SPEECH PATHOLOGY	6,952	0	6,952	0	6,952	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	274,244		274,244	0	274,244	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	424,426		424,426	0	424,426	73.00
76.00	03020 SLEEP LAB	0		0	0	0	76.00
76.01	03021 PAIN CLINIC	0		0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	19,277		19,277	0	19,277	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	2,559,044		2,559,044	0	2,559,044	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	2,263,246		2,263,246	0	2,263,246	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	209,100		209,100	0	209,100	92.00
93.00	04040 FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	17,397,753	0	17,397,753	0	17,397,753	200.00
201.00	Less Observation Beds	209,100		209,100		209,100	201.00
202.00	Total (see instructions)	17,188,653	0	17,188,653	0	17,188,653	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,079,602		1,079,602		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	144,255		144,255		44.00
46.00	04600	OTHER LONG TERM CARE	3,425,982		3,425,982		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,285	1,081,372	1,085,657	1.114570	50.00
53.00	05300	ANESTHESIOLOGY	0	166,607	166,607	0.770874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,288	3,421,695	3,534,983	0.603076	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	303,006	2,525,130	2,828,136	0.359412	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	143,424	486,769	630,193	0.211922	64.00
65.00	06500	RESPIRATORY THERAPY	155,579	153,005	308,584	0.283544	65.00
66.00	06600	PHYSICAL THERAPY	295,818	1,532,259	1,828,077	0.842609	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,428	21,666	145,094	1.043730	67.00
68.00	06800	SPEECH PATHOLOGY	2,687	1,424	4,111	1.691073	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,572	163,033	234,605	1.168961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	639,256	329,494	968,750	0.438117	73.00
76.00	03020	SLEEP LAB	0	0	0	0.000000	76.00
76.01	03021	PAIN CLINIC	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	55,731	0	55,731	0.345894	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	43,260	1,850,841	1,894,101		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	63,923	853,571	917,494	2.466769	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,000	118,280	138,280	1.512149	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
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)	6,685,096	12,705,146	19,390,242		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,685,096	12,705,146	19,390,242		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet C
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	SLEEP LAB	0.000000		76.00
76.01	03021	PAIN CLINIC	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
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 ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		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	728,016	1,085,657	0.670576	0	0	50.00
53.00	05300	ANESTHESIOLOGY	38,536	166,607	0.231299	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	953,524	3,534,983	0.269739	57,352	15,470	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	176,398	2,828,136	0.062373	149,360	9,316	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	34,738	630,193	0.055123	20,340	1,121	64.00
65.00	06500	RESPIRATORY THERAPY	24,053	308,584	0.077946	79,884	6,227	65.00
66.00	06600	PHYSICAL THERAPY	535,799	1,828,077	0.293094	21,652	6,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,874	145,094	0.288599	4,017	1,159	67.00
68.00	06800	SPEECH PATHOLOGY	268	4,111	0.065191	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,733	234,605	0.327073	27,727	9,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,213	968,750	0.067317	137,805	9,277	73.00
76.00	03020	SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	694	55,731	0.012453	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	747,036	1,894,101	0.394401	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	622,177	917,494	0.678127	35,073	23,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,280	0.000000	2,216	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	4,045,059	14,740,403		535,426	81,769	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Title XVIII			Hospital	Cost	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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	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	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		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	1,085,657	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	166,607	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,534,983	0.000000	0.000000	57,352	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	2,828,136	0.000000	0.000000	149,360	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	630,193	0.000000	0.000000	20,340	64.00
65.00	06500	RESPIRATORY THERAPY	0	308,584	0.000000	0.000000	79,884	65.00
66.00	06600	PHYSICAL THERAPY	0	1,828,077	0.000000	0.000000	21,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	145,094	0.000000	0.000000	4,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,111	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	234,605	0.000000	0.000000	27,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	968,750	0.000000	0.000000	137,805	73.00
76.00	03020	SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01	03021	PAIN CLINIC	0	0	0.000000	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	55,731	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,894,101	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	917,494	0.000000	0.000000	35,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	138,280	0.000000	0.000000	2,216	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	14,740,403			535,426	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Title XVIII			Hospital	Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School
	11.00	12.00	13.00	21.00	22.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
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
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03020 SLEEP LAB	0	0	0	0	0 76.00
76.01 03021 PAIN CLINIC	0	0	0	0	0 76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000 CLINIC	0	0	0	0	0 90.00
91.00 09100 EMERGENCY	0	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0 93.00
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: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/24/2013 2:54 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Hospital	Cost
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020 SLEEP LAB	0	0		76.00
76.01	03021 PAIN CLINIC	0	0		76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0		93.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/24/2013 2:54 pm

		Title XVIII		Hospital		Cost
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1.114570	0	364,465	0	50.00
53.00	05300 ANESTHESIOLOGY	0.770874	0	55,191	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.603076	0	1,169,333	0	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	0.359412	0	1,099,539	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.211922	0	42,030	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.283544	0	67,170	0	65.00
66.00	06600 PHYSICAL THERAPY	0.842609	0	803,543	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.043730	0	16,635	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.691073	0	626	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.168961	0	81,071	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438117	0	57,537	1,265	73.00
76.00	03020 SLEEP LAB	0.000000	0	0	0	76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.345894	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.000000				90.00
91.00	09100 EMERGENCY	2.466769	0	434,565	944	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.512149	0	98,669	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00	Subtotal (see instructions)		0	4,290,374	2,209	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	4,290,374	2,209	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/24/2013 2:54 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Costs				
		PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	406,222	0	50.00
53.00	05300	ANESTHESIOLOGY	0	42,545	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	705,197	0	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	0	395,188	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	8,907	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,046	0	65.00
66.00	06600	PHYSICAL THERAPY	0	677,073	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,362	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,059	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94,769	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,208	554	73.00
76.00	03020	SLEEP LAB	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,071,971	2,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	149,202	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
200.00		Subtotal (see instructions)	0	3,613,749	2,883	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net charges (line 200 +/- line 201)	0	3,613,749	2,883	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/24/2013 2:54 pm

Component CCN: 14Z302

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Cost	
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1.114570	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.770874	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.603076	0	0	0	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	0.359412	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.211922	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.283544	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.842609	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.043730	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.691073	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.168961	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438117	0	0	0	73.00
76.00	03020 SLEEP LAB	0.000000	0	0	0	76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.345894	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	2.466769	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.512149	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part V
Date/Time Prepared:
2/24/2013 2:54 pm

Component CCN: 142302

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
						5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
200.00		Subtotal (see instructions)	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 141302 Component CCN: 146140		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part IV Date/Time Prepared: 2/24/2013 2:54 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 141302 Component CCN: 146140	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/24/2013 2:54 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)	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	1,085,657	0.000000	0.000000	0	50.00
53.00	05300 ANESTHESIOLOGY	0	166,607	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,534,983	0.000000	0.000000	6,220	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	2,828,136	0.000000	0.000000	19,681	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	630,193	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	308,584	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,828,077	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	145,094	0.000000	0.000000	17,480	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,111	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	234,605	0.000000	0.000000	93	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	968,750	0.000000	0.000000	38,714	73.00
76.00	03020 SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01	03021 PAIN CLINIC	0	0	0.000000	0.000000	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	55,731	0.000000	0.000000	53,309	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	1,894,101	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	917,494	0.000000	0.000000	1,034	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	138,280	0.000000	0.000000	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (Lines 50-199)	0	14,740,403			136,531	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2011
To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 141302

Period: From 10/01/2011 To 09/30/2012

Worksheet D Part IV Date/Time Prepared: 2/24/2013 2:54 pm

Component CCN: 146140

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	SLEEP LAB	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
200.00		Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

worksheet D-1

Date/Time Prepared:
2/24/2013 2:54 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,008 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		657 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)		528 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		350 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)		862 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22 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)		117 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		423 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)		350 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)		862 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	125.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,047,479	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)	2,750	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)	15,210	25.00
26.00	Total swing-bed cost (see instructions)	1,982,527	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,064,952	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	808,580	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	808,580	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.317064	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)	1,531.40	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)	1,064,952	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)	1,620.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	685,653	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)	685,653	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description	Title XVIII				Hospital Program Days	Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)				
	1.00	2.00	3.00	4.00			
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)						320,323	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,005,976	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						567,326	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						1,397,242	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						1,964,568	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)						129	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,620.93	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						209,100	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/24/2013 2:54 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Date/Time Prepared:
2/24/2013 2:54 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)	381	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	381	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)	381	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)	344	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	83,534	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)	83,534	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed charges)	144,255	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	144,255	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.579072	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)	378.62	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)	83,534	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: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Component CCN: 146140

Date/Time Prepared:
2/24/2013 2:54 pm

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	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)					83,534	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					219.25	71.00
72.00 Program routine service cost (line 9 x line 71)					75,422	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)					75,422	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)					75,422	83.00
84.00 Program inpatient ancillary services (see instructions)					67,129	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)					142,551	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: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-1

Component CCN: 146140

Date/Time Prepared:
2/24/2013 2:54 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: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-3

Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Title XVIII	Hospital	Cost
		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	425,727	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,352	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	149,360	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	20,340	64.00
65.00	06500	RESPIRATORY THERAPY	79,884	65.00
66.00	06600	PHYSICAL THERAPY	21,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,805	73.00
76.00	03020	SLEEP LAB	0	76.00
76.01	03021	PAIN CLINIC	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	35,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,216	92.00
93.00	04040	FAMILY PRACTICE	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)	535,426	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)	535,426	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302
Component CCN: 14Z302

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-3

Date/Time Prepared:
2/24/2013 2:54 pm

Title XVIII		Swing Beds - SNF	Cost		
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.114570	0	50.00
53.00	05300	ANESTHESIOLOGY	0.770874	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.603076	18,470	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	0.359412	79,556	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.211922	675	64.00
65.00	06500	RESPIRATORY THERAPY	0.283544	52,576	65.00
66.00	06600	PHYSICAL THERAPY	0.842609	253,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.043730	92,763	67.00
68.00	06800	SPEECH PATHOLOGY	1.691073	2,256	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.168961	30,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.438117	283,039	73.00
76.00	03020	SLEEP LAB	0.000000	0	76.00
76.01	03021	PAIN CLINIC	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.345894	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	2.466769	21,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.512149	1,697	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		836,399	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)		836,399	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2011
To 09/30/2012

Worksheet D-3

Date/Time Prepared:
2/24/2013 2:54 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			0	30.00
41.00	04100 SUBPROVIDER - IRF			0	41.00
42.00	04200 SUBPROVIDER			0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.114570	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.770874	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.603076	6,220	3,751	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.359412	19,681	7,074	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.211922	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.283544	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.842609	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.043730	17,480	18,244	67.00
68.00	06800 SPEECH PATHOLOGY	1.691073	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.168961	93	109	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438117	38,714	16,961	73.00
76.00	03020 SLEEP LAB	0.000000	0	0	76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.345894	53,309	18,439	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2.466769	1,034	2,551	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.512149	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		136,531	67,129	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)		136,531		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/24/2013 2:54 pm

	Title XVIII	Hospital	Cost	
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,616,632	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,616,632	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,652,798	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		9,488	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		635,175	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)		2,995,058	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)		2,995,058	30.00
31.00	Primary payer payments		9,257	31.00
32.00	Subtotal (line 30 minus line 31)		2,985,801	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)		18,041	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		18,041	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,041	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		3,003,842	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		3,003,842	40.00
41.00	Interim payments		3,553,208	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)		-549,366	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: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/24/2013 2:54 pm

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2011
To 09/30/2012

Worksheet E
Part B
Date/Time Prepared:
2/24/2013 2:54 pm

Title XVIII

Skilled Nursing
Facility

PPS

1.00

PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	0	40.00
41.00	Interim payments	0	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)	0	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141302 Component CCN: 146140	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part 8 Date/Time Prepared: 2/24/2013 2:54 pm
	Title XVIII	Skilled Nursing Facility	PPS
			Overrides 1.00
112.00	WORKSHEET OVERRIDE VALUES Override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,179,271		3,632,099	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	05/25/2012	168,517	05/25/2012	51,731	3.50
3.51		09/21/2012	92,468	09/21/2012	27,160	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)		-260,985		-78,891	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)		918,286		3,553,208	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		20,785		549,366	6.02
7.00	Total Medicare program liability (see instructions)		897,501		3,003,842	7.00
		0		Contractor Number 1.00	Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302
Component CCN: 14Z302

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2013 2:54 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,272,279			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	05/25/2012	297,945			0	3.50
3.51		09/21/2012	362,342			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)		-660,287			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)		2,611,992			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		92,996			0	6.02
7.00	Total Medicare program liability (see instructions)		2,518,996			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: 141302
Component CCN: 146140

Period:
From 10/01/2011
To 09/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2013 2:54 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		75,657		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)		75,657		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)		75,657		0		7.00
		0		Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141302

Period: From 10/01/2011

Worksheet E-2

Component CCN: 142302

To 09/30/2012

Date/Time Prepared: 2/24/2013 2:54 pm

		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,984,214	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)	590,599	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,212	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,574,813	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,574,813	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,574,813	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	55,817	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,518,996	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)	2,518,996	0	19.00
20.00	Interim payments	2,611,992	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)	-92,996	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: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/24/2013 2:54 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			1,005,976 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,005,976 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,016,036 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,016,036 19.00
20.00	Deductibles (exclude professional component)			127,476 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			888,560 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			888,560 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			8,941 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			8,941 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,941 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			897,501 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			897,501 30.00
31.00	Interim payments			918,286 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			-20,785 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141302 Component CCN: 146140	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/24/2013 2:54 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)		100,199	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)		100,199	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		24,542	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		75,657	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)		75,657	15.00
16.00	Interim payments		75,657	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet G

Date/Time Prepared:
2/24/2013 2:54 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	1,610,105	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,819,373	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,549,675	0	0	0	6.00
7.00	Inventory	369,055	0	0	0	7.00
8.00	Prepaid expenses	58,880	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,884,929	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,192,667	0	0	0	11.00
FIXED ASSETS						
12.00	Land	559,916	0	0	0	12.00
13.00	Land improvements	3,713,316	0	0	0	13.00
14.00	Accumulated depreciation	-1,324,650	0	0	0	14.00
15.00	Buildings	39,130,890	0	0	0	15.00
16.00	Accumulated depreciation	-11,384,776	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,060,333	0	0	0	23.00
24.00	Accumulated depreciation	-6,673,177	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	37,053	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,118,905	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,997,638	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	825,713	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,823,351	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,134,923	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	796,574	0	0	0	37.00
38.00	Salaries, wages, and fees payable	446,734	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	720,000	0	0	0	40.00
41.00	Deferred income	96,113	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	3,341,189	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,400,610	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	44,765,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,765,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50,165,610	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,030,687	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)	-3,030,687	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,134,923	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/24/2013 2:54 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00				
2.00					2.00
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18.00					18.00
19.00					19.00
1.00					1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00					17.00
18.00					18.00
19.00					19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-1

Date/Time Prepared:
2/24/2013 2:54 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2013 2:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,079,602		1,079,602	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	144,255		144,255	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,425,982		3,425,982	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,649,839		4,649,839	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)	4,649,839		4,649,839	17.00
18.00	Ancillary services	1,905,257	0	1,905,257	18.00
19.00	Outpatient services	0	11,053,470	11,053,470	19.00
20.00	RURAL HEALTH CLINIC	0	1,784,043	1,784,043	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				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	PROFESSIONAL FEES	0	1,591,506	1,591,506	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	6,555,096	14,429,019	20,984,115	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		19,545,890		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	873,702			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)		873,702		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		20,419,592		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet G-3

Date/Time Prepared:
2/24/2013 2:54 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	20,984,115	1.00
2.00	Less contractual allowances and discounts on patients' accounts	3,797,217	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,186,898	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	20,419,592	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,232,694	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	148,416	6.00
7.00	Income from investments	94,632	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	227,684	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	2,002	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,046	22.00
23.00	Governmental appropriations	15,432	23.00
24.00	GAIN ON SALE OF EQUIPMENT	68,700	24.00
24.01	ASSISTED LIVING UNITS	653,801	24.01
24.02	ADULT DAY CARE PROGRAM	320,521	24.02
24.03	FITNESS CENTER REVENUE	122,229	24.03
24.04	GRANT REVENUE	44,790	24.04
24.05	MASSAGE THERAPY REVENUE	4,618	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	1,703,871	25.00
26.00	Total (line 5 plus line 25)	-1,528,823	26.00
27.00	EMPLOYEE LOAN FORGIVENESS	866	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	866	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,529,689	29.00

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

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-1
Date/Time Prepared:
2/24/2013 2:54 pm

				Rural Health Clinic (RHC) I		Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	790,370	0	790,370	-24,499	765,871
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	79,002	0	79,002	-33,646	45,356
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	192,496	0	192,496	0	192,496
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1-9)	1,061,868	0	1,061,868	-58,145	1,003,723
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	99,091	99,091	0	99,091
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	-2,513	-2,513
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	99,091	99,091	-2,513	96,578
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,061,868	99,091	1,160,959	-60,658	1,100,301
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	156,191	78,380	234,571	0	234,571
31.00	Total Facility Overhead (sum of lines 29 and 30)	156,191	78,380	234,571	0	234,571
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,218,059	177,471	1,395,530	-60,658	1,334,872

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

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-1
Date/Time Prepared:
2/24/2013 2:54 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	0	765,871	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	45,356	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	192,496	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	1,003,723	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	99,091	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-8,755	-11,268	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	-8,755	87,823	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,755	1,091,546	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	234,571	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	234,571	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,755	1,326,117	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141302

Period:
From 10/01/2011
To 09/30/2012

Worksheet M-2

Component CCN: 148511

Date/Time Prepared:
2/24/2013 2:54 pm

Rural Health
Clinic (RHC) I

Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.93	8,431	4,200	12,306	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.52	1,332	2,100	1,092	3.00
4.00	Subtotal (sum of lines 1-3)	3.45	9,763		13,398	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.45	9,763			8.00
9.00	Physician Services Under Agreements		0			9.00
						1.00

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from worksheet M-1, column 7, line 22)				1,091,546	10.00
11.00	Total nonreimbursable costs (from worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,091,546	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from worksheet M-1, column 7, line 31)				234,571	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,232,927	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,467,498	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				1,467,498	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,467,498	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				2,559,044	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 148511		Date/Time Prepared: 2/24/2013 2:54 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)		2,559,044	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		15,653	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,543,391	3.00
4.00	Total Visits (from worksheet M-2, column 5, line 8)		13,398	4.00
5.00	Physicians visits under agreement (from worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,398	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		189.83	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)	78.07	78.54	8.00
9.00	Rate for PROGRAM covered visits (see instructions)	189.83	189.83	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,017	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	382,887	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		382,887	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		281,609	16.04
16.05	Total program cost (see instructions)		281,609	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,876	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		76,790	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		281,609	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		11,187	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		292,796	22.00
23.00	Reimbursable bad debts (see instructions)		1,974	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		1,974	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)		294,770	26.00
27.00	Interim payments		379,180	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)		-84,410	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: 141302	Period: From 10/01/2011 To 09/30/2012	Worksheet M-4
		Component CCN: 148511		Date/Time Prepared: 2/24/2013 2:54 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)	1,003,723	1,003,723	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000290	0.001000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	291	1,004	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,918	2,464	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,209	3,468	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	1,091,546	1,091,546	6.00
7.00	Total overhead (from worksheet M-2, line 16)	1,467,498	1,467,498	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002940	0.003177	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,314	4,662	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,523	8,130	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	56	193	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	134.34	42.12	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	40	138	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,374	5,813	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)		15,653	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)		11,187	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/24/2013 2:54 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		176,033	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		05/25/2012	149,715	3.01
3.02		09/21/2012	53,432	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)		203,147	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		379,180	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)		0	6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		84,410	6.02
7.00	Total Medicare program liability (see instructions)		294,770	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00