

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: 141313	Period: From 10/01/2011 To 09/30/2012 Worksheet S Parts I-III Date/Time Prepared: 2/14/2013 4:26 pm

PART I - COST REPORT STATUS		
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/14/2013 Time: 4:26 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 MASON DISTRICT HOSPITAL (141313) 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.

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

 Title

 Date

Cost Center Description	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	13,136	-150,175	654,917	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	-35,283	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	203,251	0	0	10.00
10.01 RURAL HEALTH CLINIC II II	0	0	-2,933	0	0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-22,147	50,143	654,917	0	200.00

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

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Encryption Information
 ECR: Date: 2/14/2013 Time: 4:26 pm
 MD8QTM1ei p3S90I 1ZTDaTwZhQWk90
 4XsJb0FI I . OCI QrI hcTm: cJ0XI YqE1
 aeAX0: i sbd0rOK6x
 PI: Date: 2/14/2013 Time: 4:26 pm
 RI Al oyZ73bg0L5U6TWdgpWJCseY3: 0
 OrI OT0B. I AVI uMQ0I rq7mwDHWoe44
 CTsbZsLGzZ0um8TB

(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			
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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	-35,283	0	0	0	5.00
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10.01 RURAL HEALTH CLINIC II II	0	0	-2,933	0	0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-22,147	50,143	654,917	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/14/2013 4:25 pm							
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 615 NORTH PROMENADE STREET			PO Box:						1.00			
2.00	City: HAVANA			State: IL		Zip Code: 62644-0530		County: MASON		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
				V	XVIII	XIX							
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	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		MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00		
8.00	Swing Beds - NF										8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice										14.00		
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00		
15.01	Hospital-Based Health Clinic - RHC II		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2011	09/30/2012		20.00			
21.00	Type of Control (see instructions)						11		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						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: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/14/2013 4:25 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				
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.					39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
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: 141313

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

Worksheet S-2
Part I
Date/Time Prepared:
2/14/2013 4:25 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	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 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		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		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	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/14/2013 4:25 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	118,298	0		0
				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	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/14/2013 4:25 pm	
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						654,917	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/14/2013 4:25 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		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	01/11/2013	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141313

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

Worksheet S-2
Part II
Date/Time Prepared:
2/14/2013 4:25 pm

		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 relieved for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	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.	DAN	LI NHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LI NHART@MCGLADREY.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	01/11/2013	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
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.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Avai lable		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	19,051.40	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	19,051.40	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	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	19,051.40	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.01 RURAL HEALTH CLINIC II	88.01				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	652	62	839		1.00
2.00 HMO		19	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	576	0	594		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,228	62	1,433		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		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	1,228	62	1,433		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	5,896	0	36,086		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	5,266	0	17,649		26.00
26.01 RURAL HEALTH CLINIC II	0	342	0	2,414		26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	143		28.00
29.00 Ambulance Trips		632				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	228	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	179.64	0.00	0	228	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	12.92	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	34.21	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	3.88	0.00			26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	230.65	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	25	310		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)	25	310		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141313 Component CCN: 147202		Period: From 10/01/2011 To 09/30/2012		Worksheet S-4 Date/Time Prepared: 2/14/2013 4:25 pm		
				Home Health Agency I		PPS		
				1.00				
0.00	County	MASON				0.00		
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	922	42	195	1,159	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	232.00	11.00	49.00	292.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel				1.85	0.00	1.85	5.00
6.00	Direct Nursing Service				10.50	0.00	10.50	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				0.02	0.00	0.02	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				0.56	0.00	0.56	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914						20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	3.00	4.00	5.00		
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	3,567	240	70	7	3,884	21.00	
22.00	Skilled Nursing Visit Charges	801,021	53,790	15,729	1,575	872,115	22.00	
23.00	Physical Therapy Visits	1,021	61	13	5	1,100	23.00	
24.00	Physical Therapy Visit Charges	254,638	15,250	3,250	1,250	274,388	24.00	
25.00	Occupational Therapy Visits	530	47	4	5	586	25.00	
26.00	Occupational Therapy Visit Charges	132,559	11,750	1,000	1,250	146,559	26.00	
27.00	Speech Pathology Visits	14	4	0	0	18	27.00	
28.00	Speech Pathology Visit Charges	3,473	1,000	0	0	4,473	28.00	
29.00	Medical Social Service Visits	16	0	0	0	16	29.00	
30.00	Medical Social Service Visit Charges	3,973	0	0	0	3,973	30.00	
31.00	Home Health Aide Visits	260	31	1	0	292	31.00	
32.00	Home Health Aide Visit Charges	32,395	3,875	125	0	36,395	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,408	383	88	17	5,896	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,228,059	85,665	20,104	4,075	1,337,903	35.00	
36.00	Total Number of Episodes (standard/non outlier)	285		32	1	318	36.00	
37.00	Total Number of Outlier Episodes		7		0	7	37.00	
38.00	Total Non-Routine Medical Supply Charges	6,810	212	220	0	7,242	38.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		615 PROMENADE BOX 530				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		HAVANA		IL		62644-0530	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
		Sunday		Monday			
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00 Facility hours of operations (1)				08:00 17:00			
11.00 Clinic							
1.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
		Provider name		CCN number			
		1.00		2.00			
14.00 Provider name, CCN number						14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N		0		0	
				0		0	
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MASON		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
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: 141313 Component CCN: 143457		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 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: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm	
				Rural Health Clinic (RHC) II		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		City		State		Zip Code	
		615 N PROMENADE				1.00	
2.00 City, State, Zip Code, County		HAVANA		IL		62644	
2.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
3.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
10.00							
				Sunday		Monday	
		from		to		from	
		1.00		2.00		3.00	
						4.00	
Facility hours of operations (1)							
11.00 Clinic				08:00		17:00	
11.00							
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				0	
13.00 Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
12.00							
13.00							
				Provider name		CCN number	
				1.00		2.00	
14.00 Provider name, CCN number							
		Y/N		V		Total Visits	
		1.00		2.00		3.00	
						4.00	
						5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N		0		0	
						0	
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MASON		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
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: 141313 Component CCN: 143462		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm	
				Rural Health Clinic (RHC) II		Cost	
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic			08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/14/2013 4:25 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/14/2013 4:25 pm
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				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)			0.634358	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			1,033,954	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?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			383,360	5.00	
6.00	Medicaid charges			2,887,124	6.00	
7.00	Medicaid cost (line 1 times line 6)			1,831,470	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)			414,156	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			9,886	9.00	
10.00	Stand-alone SCHIP charges			15,743	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			9,987	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			101	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			1,122,002	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			414,257	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			422,230	32,133	454,363
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			267,845	20,384	288,229
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			267,845	20,384	288,229
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit					0
26.00	Total bad debt expense for the entire hospital complex (see instructions)					1,793,264
27.00	Medicare bad debts for the entire hospital complex (see instructions)					410,535
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)					1,382,729
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)					877,145
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)					1,165,374
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					1,579,631

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 141313		Period: From 10/01/2011 To 09/30/2012		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,029	1,029	291,203	292,232	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	66,546	66,546	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	592,064	592,064	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,044,869	1,044,869	-521,032	523,837	2.00
4.00	00400	EMPLOYEE BENEFITS	0	2,446,313	2,446,313	0	2,446,313	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	918,175	1,188,388	2,106,563	0	2,106,563	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	323,447	198,546	521,993	0	521,993	5.02
6.00	00600	MAINTENANCE & REPAIRS	288,576	154,704	443,280	0	443,280	6.00
7.00	00700	OPERATION OF PLANT	0	235,943	235,943	0	235,943	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,719	14,719	0	14,719	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	23,921	19,847	43,768	0	43,768	8.00
9.00	00900	HOUSEKEEPING	227,313	67,182	294,495	0	294,495	9.00
10.00	01000	DIETARY	205,681	178,139	383,820	0	383,820	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	198,563	27,042	225,605	0	225,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,101	6,038	77,139	0	77,139	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,087	53,108	183,195	0	183,195	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	319,711	319,711	0	319,711	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	888,842	180,729	1,069,571	0	1,069,571	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	181,847	51,290	233,137	0	233,137	50.00
53.00	05300	ANESTHESIOLOGY	0	99	99	0	99	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,106	233,252	707,358	-101,414	605,944	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	62,355	46,547	108,902	2,632	111,534	54.01
56.00	05600	RADIOISOTOPE	43,307	86,536	129,843	759	130,602	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	107,699	107,699	1,492	109,191	58.00
60.00	06000	LABORATORY	579,869	480,578	1,060,447	76,883	1,137,330	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,247	46,247	0	46,247	62.00
64.00	06400	INTRAVENOUS THERAPY	0	9,458	9,458	0	9,458	64.00
66.00	06600	PHYSICAL THERAPY	404,020	93,600	497,620	0	497,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	134,067	40,502	174,569	0	174,569	67.00
68.00	06800	SPEECH PATHOLOGY	13,273	950	14,223	0	14,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	379,185	138,598	517,783	19,648	537,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	269,966	269,966	0	269,966	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	289,305	432,020	721,325	0	721,325	73.00
76.00	03020	OP SENIOR HEALTH	287,233	156,725	443,958	0	443,958	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	1,958	11,573	13,531	0	13,531	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,536,977	568,446	3,105,423	-88,311	3,017,112	88.00
88.01	08801	RURAL HEALTH CLINIC II	235,497	61,110	296,607	0	296,607	88.01
91.00	09100	EMERGENCY	377,318	1,141,565	1,518,883	509,592	2,028,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	745,529	86,617	832,146	-509,592	322,554	95.00
101.00	10100	HOME HEALTH AGENCY	528,228	114,369	642,597	0	642,597	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		428,781	428,781	-428,781	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,549,780	10,742,835	21,292,615	-88,311	21,204,304	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	15,508	959	16,467	88,311	104,778	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,565,288	10,743,794	21,309,082	0	21,309,082	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141313

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

Worksheet A
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-25,205	267,027	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	66,546	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-48,576	543,488	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-22,414	501,423	2.00
4.00	00400	EMPLOYEE BENEFITS	-553,847	1,892,466	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	-49,227	2,057,336	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-3,834	518,159	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	443,280	6.00
7.00	00700	OPERATION OF PLANT	-388	235,555	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,719	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,768	8.00
9.00	00900	HOUSEKEEPING	0	294,495	9.00
10.00	01000	DIETARY	-128,348	255,472	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	225,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,139	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,199	176,996	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	319,711	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,764	1,066,807	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	233,137	50.00
53.00	05300	ANESTHESIOLOGY	0	99	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-25,922	580,022	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	111,534	54.01
56.00	05600	RADIOISOTOPE	0	130,602	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	109,191	58.00
60.00	06000	LABORATORY	-82	1,137,248	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,247	62.00
64.00	06400	INTRAVENOUS THERAPY	0	9,458	64.00
66.00	06600	PHYSICAL THERAPY	0	497,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	174,569	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	-33,817	503,614	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	269,966	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,125	720,200	73.00
76.00	03020	OP SENIOR HEALTH	-70	443,888	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	13,531	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-2,803	3,014,309	88.00
88.01	08801	RURAL HEALTH CLINIC II	-1,020	295,587	88.01
91.00	09100	EMERGENCY	-352,609	1,675,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-9,605	312,949	95.00
101.00	10100	HOME HEALTH AGENCY	-129	642,468	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,267,984	19,936,320	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	104,778	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,267,984	20,041,098	200.00

RECLASSIFICATIONS

Provider CCN: 141313

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

Worksheet A-6

Date/Time Prepared:
2/14/2013 4:25 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - INTEREST RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	130,496	1.00	
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	298,285	2.00	
	TOTALS		0	428,781		
B - EMS SALARY TO ER						
1.00	EMERGENCY	91.00	509,592	0	1.00	
	TOTALS		509,592	0		
C - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	160,707	1.00	
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	66,546	2.00	
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	293,779	3.00	
	TOTALS		0	521,032		
D - RHC PHYSICIAN						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,311	0	1.00	
	TOTALS		88,311	0		
E - OP REGISTRATION						
1.00	LABORATORY	60.00	68,948	7,935	1.00	
2.00	CARDIOPULMONARY	69.01	17,620	2,028	2.00	
3.00	RADIOLOGY-ULTRASOUND	54.01	2,360	272	3.00	
4.00	RADIOISOTOPE	56.00	681	78	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	4,761	548	5.00	
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,338	154	6.00	
	TOTALS		95,708	11,015		
500.00	Grand Total: Increases		693,611	960,828	500.00	

RECLASSIFICATIONS

Provider CCN: 141313

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

Worksheet A-6
Date/Time Prepared:
2/14/2013 4:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	428,781	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	428,781			
B - EMS SALARY TO ER							
1.00	AMBULANCE SERVICES	95.00	509,592	0	0		1.00
	TOTALS		509,592	0			
C - DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	521,032	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	521,032			
D - RHC PHYSICIAN							
1.00	RURAL HEALTH CLINIC	88.00	88,311	0	0		1.00
	TOTALS		88,311	0			
E - OP REGISTRATION							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	95,708	11,015	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		95,708	11,015			
500.00	Grand Total: Decreases		693,611	960,828			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/14/2013 4:25 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	1.00
2.00	Land Improvements	559,643	0	0	0	2.00
3.00	Buildings and Fixtures	12,715,123	1,557,265	0	1,557,265	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	2,570,402	195,410	0	195,410	5.00
6.00	Movable Equipment	7,599,669	0	0	0	6.00
7.00	HIT designated Assets	0	654,917	0	654,917	7.00
8.00	Subtotal (sum of lines 1-7)	23,608,765	2,407,592	0	2,407,592	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,608,765	2,407,592	0	2,407,592	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	1,029	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,044,869	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,045,898	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	17,795,474	0	17,795,474	0.684388	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,206,560	0	8,206,560	0.315612	2.00
3.00	Total (sum of lines 1-2)	26,002,034	0	26,002,034	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/14/2013 4:25 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	163,928	0			1.00	
2.00	Land Improvements	559,643	0			2.00	
3.00	Buildings and Fixtures	14,272,388	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	2,761,265	0			5.00	
6.00	Movable Equipment	7,551,643	0			6.00	
7.00	HIT designated Assets	654,917	0			7.00	
8.00	Subtotal (sum of lines 1-7)	25,963,784	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	25,963,784	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	1,029			1.00	
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0			1.01	
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0			1.02	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,044,869			2.00	
3.00	Total (sum of lines 1-2)	0	1,045,898			3.00	
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	157,536	-279	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	66,546	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	292,577	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	501,423	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,018,082	-279	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/14/2013 4:25 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	109,770	0	0	0	267,027	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	66,546	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	250,911	0	0	0	543,488	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	501,423	2.00
3.00	Total (sum of lines 1-2)	360,681	0	0	0	1,378,484	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
2/14/2013 4:25 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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			ONEW CAP REL COSTS-CLINIC BUILDING	1.01	1.01
1.02 Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			ONEW CAP REL COSTS-NEW MED SURG	1.02	1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)		0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		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	-412,152			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Cafeteria-employees and guests		0		0.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines		0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - NEW CAP REL COSTS-CLINIC BUILDING			ONEW CAP REL COSTS-CLINIC BUILDING	1.01	26.01
26.02 Depreciation - NEW CAP REL COSTS-NEW MED SURG			ONEW CAP REL COSTS-NEW MED SURG	1.02	26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant				0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-22,414	NEW CAP REL COSTS-MVBLE EQUIP	2.00	32.00
33.00 MEDICAL RECORD FEES -OTHER OP	B	-6,199	MEDICAL RECORDS & LIBRARY	16.00	33.00
33.01 CAFETERIA SALES -OTHER OP	B	-128,348	DIETARY	10.00	33.01
33.02		0		0.00	33.02
33.03 SALE OF NON-PAT SUPP-OTHER OP	B	-1,348	ADMINISTRATIVE & GENERAL	5.01	33.03
33.04 PHARMACIST REIMBURSE-OTHER OP	B	-1,125	DRUGS CHARGED TO PATIENTS	73.00	33.04
33.05 PROF BUILDING RENT -OTHER OP	B	-279	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.05
33.06 MISCELLANEOUS -OTHER OP	B	-177	ADMINISTRATIVE & GENERAL	5.01	33.06
33.07		0		0.00	33.07
33.08 LAB OUTREACH REV -OTHER OP	B	-82	LABORATORY	60.00	33.08
33.09		0		0.00	33.09
33.10		0		0.00	33.10

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center		
			1.00	2.00	
33.11 INTEREST INCOME -NON OPER	B	-20,726	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.11
33.12 INTEREST INCOME -NON OPER	B	-47,374	NEW CAP REL COSTS-NEW MED SURG	1.02	33.12
34.00		0		0.00	34.00
35.00		0		0.00	35.00
36.00 TELEPHONE OFFSET - OPERATIONS	A	-388	OPERATION OF PLANT	7.00	36.00
36.01 TELEPHONE OFFSET - SALARIES	A	-86	ADMINISTRATIVE & GENERAL	5.01	36.01
36.02 TELEPHONE OFFSET - BENEFITS	A	-14	EMPLOYEE BENEFITS	4.00	36.02
37.00		0		0.00	37.00
38.00 MEDI CAR - EXPENSES	A	-11,083	ADMINISTRATIVE & GENERAL	5.01	38.00
39.00 MEDI CAR - BENEFITS	A	-1,063	EMPLOYEE BENEFITS	4.00	39.00
39.01		0		0.00	39.01
40.00 LOBBYING DUES	A	-5,689	ADMINISTRATIVE & GENERAL	5.01	40.00
41.00		0		0.00	41.00
41.01 ADVERTISING	A	-30,844	ADMINISTRATIVE & GENERAL	5.01	41.01
42.00 ADVERTISING	A	-196	CARDIOPULMONARY	69.01	42.00
42.01 ADVERTISING	A	-129	HOME HEALTH AGENCY	101.00	42.01
43.00 ADVERTISING	A	-3,834	OTHER ADMINISTRATIVE AND GENERAL	5.02	43.00
43.01 ADVERTISING	A	-700	OP SENIOR HEALTH	76.00	43.01
43.02 ADVERTISING	A	-2,803	RURAL HEALTH CLINIC	88.00	43.02
43.03 ADVERTISING	A	-1,020	RURAL HEALTH CLINIC II	88.01	43.03
43.04 ADVERTISING	A	-759	AMBULANCE SERVICES	95.00	43.04
43.05 ADVERTISING	A	-2,764	ADULTS & PEDIATRICS	30.00	43.05
43.06		0		0.00	43.06
43.07 TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	43.07
43.08		0		0.00	43.08
44.00		0		0.00	44.00
45.00 SELF INSURANCE	A	-491,927	EMPLOYEE BENEFITS	4.00	45.00
45.01 UNFUNDED POST-EMPLOYMENT BENEFIT	A	-60,843	EMPLOYEE BENEFITS	4.00	45.01
45.02 RENTAL INCOME	B	-4,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.02
45.03 AMBULANCE INSURANCE REV	B	-8,846	AMBULANCE SERVICES	95.00	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,267,984			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
2/14/2013 4:25 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-CLINIC BUILDING (chapter 2)	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	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-CLINIC BUILDING	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	0	33.00
33.01	CAFETERIA SALES -OTHER OP	0	33.01
33.02		0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	0	33.03
33.04	PHARMACIST REIMBURSE-OTHER OP	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	10	33.05
33.06	MISCELLANEOUS -OTHER OP	0	33.06
33.07		0	33.07
33.08	LAB OUTREACH REV -OTHER OP	0	33.08
33.09		0	33.09
33.10		0	33.10
33.11	INTEREST INCOME -NON OPER	11	33.11
33.12	INTEREST INCOME -NON OPER	11	33.12
34.00		0	34.00
35.00		0	35.00
36.00	TELEPHONE OFFSET - OPERATIONS	0	36.00
36.01	TELEPHONE OFFSET - SALARIES	0	36.01
36.02	TELEPHONE OFFSET - BENEFITS	0	36.02
37.00		0	37.00
38.00	MEDICAR - EXPENSES	0	38.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
39.00	MEDICAR - BENEFITS	0	39.00
39.01		0	39.01
40.00	LOBBYING DUES	0	40.00
41.00		0	41.00
41.01	ADVERTISING	0	41.01
42.00	ADVERTISING	0	42.00
42.01	ADVERTISING	0	42.01
43.00	ADVERTISING	0	43.00
43.01	ADVERTISING	0	43.01
43.02	ADVERTISING	0	43.02
43.03	ADVERTISING	0	43.03
43.04	ADVERTISING	0	43.04
43.05	ADVERTISING	0	43.05
43.06		0	43.06
43.07	TELEVISIONS	9	43.07
43.08		0	43.08
44.00		0	44.00
45.00	SELF INSURANCE	0	45.00
45.01	UNFUNDED POST-EMPLOYMENT BENEFIT	0	45.01
45.02	RENTAL INCOME	9	45.02
45.03	AMBULANCE INSURANCE REV	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
2/14/2013 4:25 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	1,179,360	352,609	1.00
2.00		60.00	LABORATORY	48,000	0	2.00
3.00		69.01	CARDIOPULMONARY	33,621	33,621	3.00
4.00		54.00	RADIOLOGY-DIAGNOSTIC	25,922	25,922	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,286,903	412,152	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
2/14/2013 4:25 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	826,751	0	0	0	0	1.00
2.00	48,000	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	874,751					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
2/14/2013 4:25 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
2/14/2013 4:25 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	352,609	1.00
2.00	0	0	2.00
3.00	0	33,621	3.00
4.00	0	25,922	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	412,152	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW MVBLE EQUIP	
		0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	267,027	267,027			1.00
1.01 00101	NEW CAP REL COSTS-CLINIC BUILDING	66,546	0	66,546		1.01
1.02 00102	NEW CAP REL COSTS-NEW MED SURG	543,488	0	0	543,488	1.02
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	501,423				501,423 2.00
4.00 00400	EMPLOYEE BENEFITS	1,892,466	0	0	0	0 4.00
5.01 00510	ADMINISTRATIVE & GENERAL	2,057,336	53,717	3,530	75,155	32,093 5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	518,159	2,637	4,348	4,461	6,051 5.02
6.00 00600	MAINTENANCE & REPAIRS	443,280	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	235,555	27,446	557	11,896	0 7.00
7.01 00701	OPERATION OF PLANT-CLINIC	14,719	0	0	0	0 7.01
8.00 00800	LAUNDRY & LINEN SERVICE	43,768	8,083	0	4,421	582 8.00
9.00 00900	HOUSEKEEPING	294,495	969	0	2,612	0 9.00
10.00 01000	DIETARY	255,472	13,140	0	0	405 10.00
11.00 01100	CAFETERIA	0	5,586	0	3,014	0 11.00
13.00 01300	NURSING ADMINISTRATION	225,605	5,446	0	6,471	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	77,139	7,026	0	0	0 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	176,996	6,632	676	0	1,133 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	319,711	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,066,807	4,000	0	423,682	11,052 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	233,137	32,343	0	0	52,028 50.00
53.00 05300	ANESTHESIOLOGY	99	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	580,022	24,348	0	0	215,045 54.00
54.01 05401	RADIOLOGY-ULTRASOUND	111,534	1,259	0	0	0 54.01
56.00 05600	RADIOISOTOPE	130,602	2,736	0	0	1,928 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	109,191	0	0	0	0 58.00
60.00 06000	LABORATORY	1,137,248	14,026	0	0	24,615 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,247	0	0	0	0 62.00
64.00 06400	INTRAVENOUS THERAPY	9,458	0	0	0	0 64.00
66.00 06600	PHYSICAL THERAPY	497,620	5,337	0	0	83,601 66.00
67.00 06700	OCCUPATIONAL THERAPY	174,569	1,119	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	14,223	808	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
69.01 03160	CARDIOPULMONARY	503,614	25,213	0	0	12,865 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	269,966	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	720,200	3,979	0	0	5,590 73.00
76.00 03020	OP SENIOR HEALTH	443,888	0	2,832	0	0 76.00
76.01 03021	TELEMEDICINE-PSYCHIATRIC SERVICES	13,531	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	3,014,309	0	48,837	0	4,088 88.00
88.01 08801	RURAL HEALTH CLINIC II	295,587	0	0	0	942 88.01
91.00 09100	EMERGENCY	1,675,866	21,177	0	0	4,191 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	312,949	0	0	0	36,630 95.00
101.00 10100	HOME HEALTH AGENCY	642,468	0	5,766	0	7,992 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,936,320	267,027	66,546	531,712	500,831 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,776	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	104,778	0	0	0	592 192.00
194.00 07950	HOSPICE	0	0	0	0	0 194.00
194.01 07951	FAMILY MEDICAL CENTER	0	0	0	0	0 194.01
194.02 07952	MEALS ON WHEELS	0	0	0	0	0 194.02
194.04 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	20,041,098	267,027	66,546	543,488	501,423 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description			EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	4A	5.01	5A.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	1,892,466					4.00
5.01	00510	ADMINISTRATIVE & GENERAL	163,876	2,385,707	2,385,707			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	58,151	593,807	80,239	674,046	674,046	5.02
6.00	00600	MAINTENANCE & REPAIRS	51,882	495,162	66,909	562,071	27,047	6.00
7.00	00700	OPERATION OF PLANT	0	275,454	37,221	312,675	15,046	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,719	1,989	16,708	804	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	4,301	61,155	8,264	69,419	3,340	8.00
9.00	00900	HOUSEKEEPING	40,867	338,943	45,800	384,743	18,514	9.00
10.00	01000	DIETARY	36,978	305,995	41,348	347,343	16,714	10.00
11.00	01100	CAFETERIA	0	8,600	1,162	9,762	470	11.00
13.00	01300	NURSING ADMINISTRATION	35,699	273,221	36,919	310,140	14,924	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,783	96,948	13,100	110,048	5,296	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,388	208,825	28,218	237,043	11,407	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	319,711	43,201	362,912	17,463	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	159,800	1,665,341	225,031	1,890,372	90,965	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,693	350,201	47,321	397,522	19,129	50.00
53.00	05300	ANESTHESIOLOGY	0	99	13	112	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,027	888,442	120,052	1,008,494	48,529	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	11,631	124,424	16,813	141,237	6,796	54.01
56.00	05600	RADIOISOTOPE	7,907	143,173	19,346	162,519	7,820	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239	109,430	14,787	124,217	5,977	58.00
60.00	06000	LABORATORY	116,541	1,292,430	174,641	1,467,071	70,595	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,247	6,249	52,496	2,526	62.00
64.00	06400	INTRAVENOUS THERAPY	0	9,458	1,278	10,736	517	64.00
66.00	06600	PHYSICAL THERAPY	72,637	659,195	89,074	748,269	36,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,103	199,791	26,997	226,788	10,913	67.00
68.00	06800	SPEECH PATHOLOGY	2,386	17,417	2,353	19,770	951	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	65,494	607,186	82,047	689,233	33,166	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	269,966	36,479	306,445	14,746	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,013	781,782	105,639	887,421	42,703	73.00
76.00	03020	OP SENIOR HEALTH	51,640	498,360	67,341	565,701	27,222	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	352	13,883	1,876	15,759	758	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	440,236	3,507,470	473,957	3,981,427	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	42,339	338,868	45,790	384,658	0	88.01
91.00	09100	EMERGENCY	159,453	1,860,687	251,427	2,112,114	101,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	42,418	391,997	52,969	444,966	21,412	95.00
101.00	10100	HOME HEALTH AGENCY	94,967	751,193	101,506	852,699	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,873,801	19,905,287	2,367,356	19,886,936	673,403	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,776	1,591	13,367	643	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,665	124,035	16,760	140,795	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,892,466	20,041,098	2,385,707	20,041,098	674,046	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS	589,118				6.00
7.00	00700	OPERATION OF PLANT	49,671	377,392			7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	17,512		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	14,425	13,394	0	100,578	8.00
9.00	00900	HOUSEKEEPING	2,187	2,030	0	0	407,474
10.00	01000	DIETARY	21,918	20,352	0	0	17,082
11.00	01100	CAFETERIA	9,965	9,253	0	0	7,766
13.00	01300	NURSING ADMINISTRATION	8,237	7,648	0	0	6,419
14.00	01400	CENTRAL SERVICES & SUPPLY	11,720	10,882	0	0	9,134
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	12,679	11,773	226	0	9,882
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	97,786	90,798	0	45,169	76,210
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	53,949	50,093	0	13,598	42,045
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,613	37,710	0	11,732	35,208
54.01	05401	RADIOLOGY-ULTRASOUND	2,100	1,950	0	0	1,637
56.00	05600	RADIOISOTOPE	4,563	4,237	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	23,396	21,724	0	135	18,234
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	8,902	8,266	0	3,130	6,938
67.00	06700	OCCUPATIONAL THERAPY	1,867	1,733	0	0	1,455
68.00	06800	SPEECH PATHOLOGY	1,348	1,252	0	0	1,051
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03160	CARDIOPULMONARY	42,056	39,051	0	2,476	32,777
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,638	6,163	0	0	5,173
76.00	03020	OP SENIOR HEALTH	6,767	6,284	947	0	5,274
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	116,698	0	16,339	892	90,948
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	155	0
91.00	09100	EMERGENCY	35,324	32,799	0	19,073	27,530
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	4,175	0
101.00	10100	HOME HEALTH AGENCY	13,777	0	0	43	10,737
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	586,586	377,392	17,512	100,578	405,500
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,532	0	0	0	1,974
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	HOSPICE	0	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	589,118	377,392	17,512	100,578	407,474

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
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
9.00	00900						9.00
10.00	01000	423,409					10.00
11.00	01100	298,865	336,081				11.00
13.00	01300	0	4,224	351,592			13.00
14.00	01400	0	4,676	0	151,756		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	8,809	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	96,259	46,892	189,057	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,101	9,600	38,716	531	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	22,023	0	6,038	0	54.00
54.01	05401	0	2,485	0	98	0	54.01
56.00	05600	0	1,242	0	16,018	0	56.00
58.00	05800	0	136	0	959	0	58.00
60.00	06000	0	27,760	0	51,017	0	60.00
62.00	06200	0	0	0	11,026	0	62.00
64.00	06400	0	0	0	2,255	0	64.00
66.00	06600	0	14,953	0	0	0	66.00
67.00	06700	0	4,450	0	0	0	67.00
68.00	06800	0	248	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	0	24,440	0	5,291	0	69.01
71.00	07100	0	0	0	56,595	0	71.00
73.00	07300	0	8,809	0	0	0	73.00
76.00	03020	24,700	13,598	54,812	14	0	76.00
76.01	03021	0	113	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	76,706	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
91.00	09100	484	63,494	69,007	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	1,914	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		423,409	334,658	351,592	151,756	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,423	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		423,409	336,081	351,592	151,756	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	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-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					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-CLINIC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	291,819				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	380,375			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,961	0	2,641,469	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,850	0	637,134	0	50.00
53.00	05300	ANESTHESIOLOGY	6,062	380,375	386,554	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,816	0	1,254,163	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4,111	0	160,414	0	54.01
56.00	05600	RADIO SOTOP	5,654	0	202,053	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,084	0	140,373	0	58.00
60.00	06000	LABORATORY	58,369	0	1,738,301	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	721	0	66,769	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2,258	0	15,766	0	64.00
66.00	06600	PHYSICAL THERAPY	12,917	0	839,382	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,162	0	250,368	0	67.00
68.00	06800	SPEECH PATHOLOGY	159	0	24,779	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	16,376	0	884,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,469	0	384,255	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,063	0	966,970	0	73.00
76.00	03020	OP SENIOR HEALTH	12,229	0	717,548	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	525	0	17,155	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	26,926	0	4,309,936	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,239	0	387,052	0	88.01
91.00	09100	EMERGENCY	16,578	0	2,478,044	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	13,049	0	485,516	0	95.00
101.00	10100	HOME HEALTH AGENCY	14,241	0	891,497	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	291,819	380,375	19,880,364	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,516	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	142,218	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	291,819	380,375	20,041,098	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW MVBLE EQUIP	
		1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02 00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.01 00510	ADMINISTRATIVE & GENERAL	0	53,717	3,530	75,155	32,093
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	0	2,637	4,348	4,461	6,051
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	27,446	557	11,896	0
7.01 00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,083	0	4,421	582
9.00 00900	HOUSEKEEPING	0	969	0	2,612	0
10.00 01000	DIETARY	0	13,140	0	0	405
11.00 01100	CAFETERIA	0	5,586	0	3,014	0
13.00 01300	NURSING ADMINISTRATION	0	5,446	0	6,471	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,026	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	6,632	676	0	1,133
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	4,000	0	423,682	11,052
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	32,343	0	0	52,028
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	24,348	0	0	215,045
54.01 05401	RADIOLOGY-ULTRASOUND	0	1,259	0	0	0
56.00 05600	RADIOISOTOPE	0	2,736	0	0	1,928
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	0	14,026	0	0	24,615
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	5,337	0	0	83,601
67.00 06700	OCCUPATIONAL THERAPY	0	1,119	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	808	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01 03160	CARDIOPULMONARY	0	25,213	0	0	12,865
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	3,979	0	0	5,590
76.00 03020	OP SENIOR HEALTH	0	0	2,832	0	0
76.01 03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	48,837	0	4,088
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	942
91.00 09100	EMERGENCY	0	21,177	0	0	4,191
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	36,630
101.00 10100	HOME HEALTH AGENCY	0	0	5,766	0	7,992
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	267,027	66,546	531,712	500,831
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,776	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	592
194.00 07950	HOSPICE	0	0	0	0	0
194.01 07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
194.04 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	0	267,027	66,546	543,488	501,423

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/14/2013 4:25 pm		
Cost Center Description		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS
		2A	4.00	5.01	5.02	6.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS	0			4.00
5.01	00510	ADMINISTRATIVE & GENERAL	164,495	0	164,495	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	17,497	0	5,532	23,029
6.00	00600	MAINTENANCE & REPAIRS	0	0	4,613	924
7.00	00700	OPERATION OF PLANT	39,899	0	2,566	514
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	137	27
8.00	00800	LAUNDRY & LINEN SERVICE	13,086	0	570	114
9.00	00900	HOUSEKEEPING	3,581	0	3,158	633
10.00	01000	DIETARY	13,545	0	2,851	571
11.00	01100	CAFETERIA	8,600	0	80	16
13.00	01300	NURSING ADMINISTRATION	11,917	0	2,546	510
14.00	01400	CENTRAL SERVICES & SUPPLY	7,026	0	903	181
15.00	01500	PHARMACY	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	8,441	0	1,946	390
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,979	597
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	438,734	0	15,516	3,108
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,371	0	3,263	654
53.00	05300	ANESTHESIOLOGY	0	0	1	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,393	0	8,278	1,658
54.01	05401	RADIOLOGY-ULTRASOUND	1,259	0	1,159	232
56.00	05600	RADIOISOTOPE	4,664	0	1,334	267
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,020	204
60.00	06000	LABORATORY	38,641	0	12,042	2,412
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	431	86
64.00	06400	INTRAVENOUS THERAPY	0	0	88	18
66.00	06600	PHYSICAL THERAPY	88,938	0	6,142	1,230
67.00	06700	OCCUPATIONAL THERAPY	1,119	0	1,861	373
68.00	06800	SPEECH PATHOLOGY	808	0	162	33
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
69.01	03160	CARDIOPULMONARY	38,078	0	5,657	1,133
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,515	504
73.00	07300	DRUGS CHARGED TO PATIENTS	9,569	0	7,284	1,459
76.00	03020	OP SENIOR HEALTH	2,832	0	4,643	930
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	129	26
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	52,925	0	32,679	0
88.01	08801	RURAL HEALTH CLINIC II	942	0	3,157	0
91.00	09100	EMERGENCY	25,368	0	17,336	3,471
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	36,630	0	3,652	732
101.00	10100	HOME HEALTH AGENCY	13,758	0	6,999	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,366,116	0	163,229	23,007
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,776	0	110	22
192.00	19200	PHYSICIANS' PRIVATE OFFICES	592	0	1,156	0
194.00	07950	HOSPICE	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
200.00		Cross Foot Adjustments	0			
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,378,484	0	164,495	23,029

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/14/2013 4:25 pm
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	43,446				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	164			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,542	0	15,448		8.00
9.00	00900	HOUSEKEEPING	234	0	0	7,627	9.00
10.00	01000	DIETARY	2,343	0	0	320	10.00
11.00	01100	CAFETERIA	1,065	0	0	145	14,001
13.00	01300	NURSING ADMINISTRATION	880	0	0	120	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,253	0	0	171	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,355	2	0	185	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,451	0	6,936	1,426	4,510
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,767	0	2,089	787	145
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,341	0	1,802	659	0
54.01	05401	RADIOLOGY-ULTRASOUND	225	0	0	31	0
56.00	05600	RADIOISOTOPE	488	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	2,501	0	21	341	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	952	0	481	130	0
67.00	06700	OCCUPATIONAL THERAPY	200	0	0	27	0
68.00	06800	SPEECH PATHOLOGY	144	0	0	20	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03160	CARDIOPULMONARY	4,496	0	380	614	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	710	0	0	97	0
76.00	03020	OP SENIOR HEALTH	723	9	0	99	1,157
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	153	137	1,702	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	24	0	0
91.00	09100	EMERGENCY	3,776	0	2,930	515	23
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	641	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	7	201	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,446	164	15,448	7,590	19,836
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	37	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	HOSPICE	0	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	43,446	164	15,448	7,627	19,836

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141313		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/14/2013 4:25 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	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-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					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-CLINIC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	24,001				11.00
13.00	01300	NURSING ADMINISTRATION	302	16,352			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	334	0	9,978		14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	629	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	13,067	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,349	8,793	0	0	804
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	686	1,801	35	0	396
53.00	05300	ANESTHESIOLOGY	0	0	0	0	271
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,573	0	397	0	1,962
54.01	05401	RADIOLOGY-ULTRASOUND	177	0	6	0	184
56.00	05600	RADIOISOTOPE	89	0	1,053	0	253
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10	0	63	0	407
60.00	06000	LABORATORY	1,982	0	3,354	0	2,615
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	725	0	32
64.00	06400	INTRAVENOUS THERAPY	0	0	148	0	101
66.00	06600	PHYSICAL THERAPY	1,068	0	0	0	578
67.00	06700	OCCUPATIONAL THERAPY	318	0	0	0	142
68.00	06800	SPEECH PATHOLOGY	18	0	0	0	7
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03160	CARDIOPULMONARY	1,745	0	348	0	733
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,722	0	290
73.00	07300	DRUGS CHARGED TO PATIENTS	629	0	0	0	451
76.00	03020	OP SENIOR HEALTH	971	2,549	1	0	548
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	8	0	0	0	23
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,477	0	0	0	1,206
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	100
91.00	09100	EMERGENCY	4,534	3,209	0	0	742
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	126	0	584
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	638
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,899	16,352	9,978	0	13,067
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	102	0	0	0	0
194.00	07950	HOSPICE	0	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	24,001	16,352	9,978	0	13,067

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/14/2013 4:25 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-CLINIC BUILDING			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.01	00510	ADMINISTRATIVE & GENERAL			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-CLINIC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,576		19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	494,546	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	100,501	0	50.00
53.00	05300	ANESTHESIOLOGY	272	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,445	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	3,293	0	54.01
56.00	05600	RADIOISOTOPE	8,191	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,704	0	58.00
60.00	06000	LABORATORY	64,129	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,274	0	62.00
64.00	06400	INTRAVENOUS THERAPY	355	0	64.00
66.00	06600	PHYSICAL THERAPY	99,603	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,058	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,205	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	53,579	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,031	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,261	0	73.00
76.00	03020	OP SENIOR HEALTH	14,526	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	186	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	95,374	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,223	0	88.01
91.00	09100	EMERGENCY	62,236	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	42,365	0	95.00
101.00	10100	HOME HEALTH AGENCY	21,732	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,361,089	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,969	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,850	0	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00		Cross Foot Adjustments	3,576	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,576	1,378,484	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	51,535				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				520,043	2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	10,526,257	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	10,367	976	1,870	33,285	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	509	1,202	111	6,276	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	288,576	6.00
7.00	00700	OPERATION OF PLANT	5,297	154	296	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	604	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	9.00
10.00	01000	DIETARY	2,536	0	0	420	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	0	161	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	1,175	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	772	0	10,542	11,462	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,242	0	0	53,960	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	0	223,028	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	54.01
56.00	05600	RADIOISOTOPE	528	0	0	2,000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	0	25,529	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	86,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	13,343	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	5,798	73.00
76.00	03020	OP SENIOR HEALTH	0	783	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	4,240	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	977	88.01
91.00	09100	EMERGENCY	4,087	0	0	4,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	37,990	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	8,289	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,535	18,398	13,230	519,429	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	614	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
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)	267,027	66,546	543,488	501,423	1,892,466
203.00		Unit cost multiplier (Wkst. B, Part I)	5.181469	3.617024	40.189899	0.964195	0.179785
204.00		Cost to be allocated (per Wkst. B, Part II)					0
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	-2,385,707	17,655,391				5.01
5.02	00560	0	593,807	-674,046	14,007,473		5.02
6.00	00600	0	495,162	0	562,071	68,162	6.00
7.00	00700	0	275,454	0	312,675	5,747	7.00
7.01	00701	0	14,719	0	16,708	0	7.01
8.00	00800	0	61,155	0	69,419	1,669	8.00
9.00	00900	0	338,943	0	384,743	253	9.00
10.00	01000	0	305,995	0	347,343	2,536	10.00
11.00	01100	0	8,600	0	9,762	1,153	11.00
13.00	01300	0	273,221	0	310,140	953	13.00
14.00	01400	0	96,948	0	110,048	1,356	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	208,825	0	237,043	1,467	16.00
19.00	01900	0	319,711	0	362,912	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,665,341	0	1,890,372	11,314	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	350,201	0	397,522	6,242	50.00
53.00	05300	0	99	0	112	0	53.00
54.00	05400	0	888,442	0	1,008,494	4,699	54.00
54.01	05401	0	124,424	0	141,237	243	54.01
56.00	05600	0	143,173	0	162,519	528	56.00
58.00	05800	0	109,430	0	124,217	0	58.00
60.00	06000	0	1,292,430	0	1,467,071	2,707	60.00
62.00	06200	0	46,247	0	52,496	0	62.00
64.00	06400	0	9,458	0	10,736	0	64.00
66.00	06600	0	659,195	0	748,269	1,030	66.00
67.00	06700	0	199,791	0	226,788	216	67.00
68.00	06800	0	17,417	0	19,770	156	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	0	607,186	0	689,233	4,866	69.01
71.00	07100	0	269,966	0	306,445	0	71.00
73.00	07300	0	781,782	0	887,421	768	73.00
76.00	03020	0	498,360	0	565,701	783	76.00
76.01	03021	0	13,883	0	15,759	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	3,507,470	-3,981,427	0	13,502	88.00
88.01	08801	0	338,868	-384,658	0	0	88.01
91.00	09100	0	1,860,687	0	2,112,114	4,087	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	391,997	0	444,966	0	95.00
101.00	10100	0	751,193	-852,699	0	1,594	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		-2,385,707	17,519,580	-5,892,830	13,994,106	67,869	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	11,776	0	13,367	293	190.00
192.00	19200	0	124,035	-140,795	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00			2,385,707		674,046	589,118	202.00
203.00			0.135126		0.048120	8.642910	203.00
204.00			164,495		23,029	5,537	204.00
205.00			0.009317		0.001644	0.081233	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		7.00	7.01	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01	
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.01	00510	ADMINISTRATIVE & GENERAL					5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT	47,026				7.00	
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472			7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	65,525		8.00	
9.00	00900	HOUSEKEEPING	253	0	0	60,493	9.00	
10.00	01000	DIETARY	2,536	0	0	2,536	10.00	
11.00	01100	CAFETERIA	1,153	0	0	1,153	11.00	
13.00	01300	NURSING ADMINISTRATION	953	0	0	953	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,467	187	0	1,467	16.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,314	0	29,427	11,314	6,364	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,242	0	8,859	6,242	205	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	7,643	5,227	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	88	2,707	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	2,039	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	1,613	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	768	0	73.00
76.00	03020	OP SENIOR HEALTH	783	783	0	783	1,633	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	13,502	581	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	101	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	12,426	4,087	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	2,720	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	28	1,594	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,026	14,472	65,525	60,200	27,993	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	377,392	17,512	100,578	407,474	423,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.025178	1.210061	1.534956	6.735887	15.125531	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,446	164	15,448	7,627	19,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.923872	0.011332	0.235757	0.126081	0.708606	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITION)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
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
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	14,879					11.00
13.00	01300		80,297				13.00
14.00	01400			636,547			14.00
15.00	01500				0		15.00
16.00	01600	390				31,339,329	16.00
19.00	01900					0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,076	43,177	0	0	1,928,754	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	425	8,842	2,227	0	950,422	50.00
53.00	05300	0	0	0	0	650,991	53.00
54.00	05400	975	0	25,325	0	4,705,286	54.00
54.01	05401	110	0	412	0	441,471	54.01
56.00	05600	55	0	67,189	0	607,182	56.00
58.00	05800	6	0	4,024	0	975,467	58.00
60.00	06000	1,229	0	213,992	0	6,269,942	60.00
62.00	06200	0	0	46,247	0	77,457	62.00
64.00	06400	0	0	9,458	0	242,481	64.00
66.00	06600	662	0	0	0	1,387,115	66.00
67.00	06700	197	0	0	0	339,528	67.00
68.00	06800	11	0	0	0	17,034	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	1,082	0	22,195	0	1,758,583	69.01
71.00	07100	0	0	237,390	0	694,655	71.00
73.00	07300	390	0	0	0	1,080,658	73.00
76.00	03020	602	12,518	58	0	1,313,216	76.00
76.01	03021	5	0	0	0	56,350	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,396	0	0	0	2,891,498	88.00
88.01	08801	0	0	0	0	240,409	88.01
91.00	09100	2,811	15,760	0	0	1,780,235	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	8,030	0	1,401,328	95.00
101.00	10100	0	0	0	0	1,529,267	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		14,816	80,297	636,547	0	31,339,329	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	63	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		336,081	351,592	151,756	0	291,819	202.00
203.00		22.587607	4.378644	0.238405	0.000000	0.009312	203.00
204.00		24,001	16,352	9,978	0	13,067	204.00
205.00		1.613079	0.203644	0.015675	0.000000	0.000417	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	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-CLINIC	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	OP SENIOR HEALTH	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	HOSPICE	194.00
194.01	07951	FAMILY MEDICAL CENTER	194.01
194.02	07952	MEALS ON WHEELS	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	194.04
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)	202.00
		380,375	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		3,803.750000	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		3,576	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		35.760000	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,641,469		2,641,469	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	637,134		637,134	0	0 50.00
53.00	05300 ANESTHESIOLOGY	386,554		386,554	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,254,163		1,254,163	0	0 54.00
54.01	05401 RADIOLOGY-ULTRASOUND	160,414		160,414	0	0 54.01
56.00	05600 RADIOISOTOPE	202,053		202,053	0	0 56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	140,373		140,373	0	0 58.00
60.00	06000 LABORATORY	1,738,301		1,738,301	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	66,769		66,769	0	0 62.00
64.00	06400 INTRAVENOUS THERAPY	15,766		15,766	0	0 64.00
66.00	06600 PHYSICAL THERAPY	839,382	0	839,382	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	250,368	0	250,368	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	24,779	0	24,779	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
69.01	03160 CARDIOPULMONARY	884,866		884,866	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	384,255		384,255	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	966,970		966,970	0	0 73.00
76.00	03020 OP SENIOR HEALTH	717,548		717,548	0	0 76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	17,155		17,155	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	4,309,936		4,309,936	0	0 88.00
88.01	08801 RURAL HEALTH CLINIC II	387,052		387,052	0	0 88.01
91.00	09100 EMERGENCY	2,478,044		2,478,044	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	239,677		239,677	0	0 92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	485,516		485,516	0	0 95.00
101.00	10100 HOME HEALTH AGENCY	891,497		891,497	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	20,120,041	0	20,120,041	0	0 200.00
201.00	Less Observation Beds	239,677		239,677		0 201.00
202.00	Total (see instructions)	19,880,364	0	19,880,364	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/14/2013 4:25 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	1,664,016		1,664,016	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	107,198	843,224	950,422	50.00
53.00	05300	ANESTHESIOLOGY	69,936	581,055	650,991	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,532	4,464,754	4,705,286	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	37,936	403,535	441,471	54.01
56.00	05600	RADIOISOTOPE	14,960	592,222	607,182	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	48,531	926,936	975,467	58.00
60.00	06000	LABORATORY	631,080	5,638,862	6,269,942	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,528	37,929	77,457	62.00
64.00	06400	INTRAVENOUS THERAPY	45,948	196,533	242,481	64.00
66.00	06600	PHYSICAL THERAPY	194,630	1,192,485	1,387,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,321	179,207	339,528	67.00
68.00	06800	SPEECH PATHOLOGY	5,137	11,897	17,034	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	324,896	1,433,687	1,758,583	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	303,896	390,759	694,655	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	375,709	704,949	1,080,658	73.00
76.00	03020	OP SENIOR HEALTH	0	1,313,216	1,313,216	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	56,350	56,350	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,891,498	2,891,498	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	240,409	240,409	88.01
91.00	09100	EMERGENCY	29,328	1,750,907	1,780,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,500	260,238	264,738	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,177	1,399,151	1,401,328	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,529,267	1,529,267	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	4,300,259	27,039,070	31,339,329	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	4,300,259	27,039,070	31,339,329	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/14/2013 4:25 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
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
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
69.01	03160 CARDIOPULMONARY	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 OP SENIOR HEALTH	0.000000		76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/14/2013 4:25 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,641,469		2,641,469	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	637,134		637,134	0	0	50.00
53.00	05300 ANESTHESIOLOGY	386,554		386,554	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,254,163		1,254,163	0	0	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	160,414		160,414	0	0	54.01
56.00	05600 RADIOISOTOPE	202,053		202,053	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	140,373		140,373	0	0	58.00
60.00	06000 LABORATORY	1,738,301		1,738,301	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	66,769		66,769	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	15,766		15,766	0	0	64.00
66.00	06600 PHYSICAL THERAPY	839,382	0	839,382	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	250,368	0	250,368	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	24,779	0	24,779	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160 CARDIOPULMONARY	884,866		884,866	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	384,255		384,255	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	966,970		966,970	0	0	73.00
76.00	03020 OP SENIOR HEALTH	717,548		717,548	0	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	17,155		17,155	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	4,309,936		4,309,936	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	387,052		387,052	0	0	88.01
91.00	09100 EMERGENCY	2,478,044		2,478,044	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	239,677		239,677	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	485,516		485,516	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	891,497		891,497	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	20,120,041	0	20,120,041	0	0	200.00
201.00	Less Observation Beds	239,677		239,677			201.00
202.00	Total (see instructions)	19,880,364	0	19,880,364	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/14/2013 4:25 pm
		Title XIX	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	1,664,016		1,664,016	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	107,198	843,224	950,422	50.00
53.00	05300	ANESTHESIOLOGY	69,936	581,055	650,991	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,532	4,464,754	4,705,286	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	37,936	403,535	441,471	54.01
56.00	05600	RADIOISOTOPE	14,960	592,222	607,182	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	48,531	926,936	975,467	58.00
60.00	06000	LABORATORY	631,080	5,638,862	6,269,942	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,528	37,929	77,457	62.00
64.00	06400	INTRAVENOUS THERAPY	45,948	196,533	242,481	64.00
66.00	06600	PHYSICAL THERAPY	194,630	1,192,485	1,387,115	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,321	179,207	339,528	67.00
68.00	06800	SPEECH PATHOLOGY	5,137	11,897	17,034	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	324,896	1,433,687	1,758,583	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	303,896	390,759	694,655	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	375,709	704,949	1,080,658	73.00
76.00	03020	OP SENIOR HEALTH	0	1,313,216	1,313,216	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	56,350	56,350	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,891,498	2,891,498	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	240,409	240,409	88.01
91.00	09100	EMERGENCY	29,328	1,750,907	1,780,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,500	260,238	264,738	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,177	1,399,151	1,401,328	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,529,267	1,529,267	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	4,300,259	27,039,070	31,339,329	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	4,300,259	27,039,070	31,339,329	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/14/2013 4:25 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
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
69.01	03160 CARDIOPULMONARY	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 OP SENIOR HEALTH	0.000000		76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141313

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

Worksheet D
Part II
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	100,501	950,422	0.105744	81,180	8,584	50.00
53.00	05300 ANESTHESIOLOGY	272	650,991	0.000418	54,213	23	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	260,445	4,705,286	0.055352	162,061	8,970	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	3,293	441,471	0.007459	26,601	198	54.01
56.00	05600 RADIOISOTOPE	8,191	607,182	0.013490	7,314	99	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,704	975,467	0.001747	35,695	62	58.00
60.00	06000 LABORATORY	64,129	6,269,942	0.010228	387,411	3,962	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,274	77,457	0.016448	26,342	433	62.00
64.00	06400 INTRAVENOUS THERAPY	355	242,481	0.001464	26,852	39	64.00
66.00	06600 PHYSICAL THERAPY	99,603	1,387,115	0.071806	55,851	4,010	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,058	339,528	0.011952	36,300	434	67.00
68.00	06800 SPEECH PATHOLOGY	1,205	17,034	0.070741	1,562	110	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	53,579	1,758,583	0.030467	214,583	6,538	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,031	694,655	0.010122	161,968	1,639	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,261	1,080,658	0.018749	195,273	3,661	73.00
76.00	03020 OP SENIOR HEALTH	14,526	1,313,216	0.011061	0	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	186	56,350	0.003301	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	95,374	2,891,498	0.032984	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	4,223	240,409	0.017566	0	0	88.01
91.00	09100 EMERGENCY	62,236	1,780,235	0.034959	364	13	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	264,738	0.000000	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	802,446	26,744,718		1,473,570	38,775	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		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	380,375	0	0	0	380,375	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
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	
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00	
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50-199)	380,375	0	0	0	380,375	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/14/2013 4:25 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	Cost	
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	950,422	0.000000	0.000000	81,180	50.00
53.00	05300	ANESTHESIOLOGY	0	650,991	0.584301	0.000000	54,213	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,705,286	0.000000	0.000000	162,061	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	441,471	0.000000	0.000000	26,601	54.01
56.00	05600	RADIOISOTOPE	0	607,182	0.000000	0.000000	7,314	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	975,467	0.000000	0.000000	35,695	58.00
60.00	06000	LABORATORY	0	6,269,942	0.000000	0.000000	387,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	77,457	0.000000	0.000000	26,342	62.00
64.00	06400	INTRAVENOUS THERAPY	0	242,481	0.000000	0.000000	26,852	64.00
66.00	06600	PHYSICAL THERAPY	0	1,387,115	0.000000	0.000000	55,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	339,528	0.000000	0.000000	36,300	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,034	0.000000	0.000000	1,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,758,583	0.000000	0.000000	214,583	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	694,655	0.000000	0.000000	161,968	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,080,658	0.000000	0.000000	195,273	73.00
76.00	03020	OP SENIOR HEALTH	0	1,313,216	0.000000	0.000000	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	56,350	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,891,498	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	240,409	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	1,780,235	0.000000	0.000000	364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	264,738	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (Lines 50-199)	0	26,744,718			1,473,570	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
2/14/2013 4:25 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	31,677	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (Lines 50-199)	31,677	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/14/2013 4:25 pm
	Title XVIII	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
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
69.01 03160 CARDIOPULMONARY	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 OP SENIOR HEALTH	0	0		76.00
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/14/2013 4:25 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see inst.)	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	0.670370	0	407,953	0	50.00
53.00 05300 ANESTHESIOLOGY	0.593793	0	290,492	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.266543	0	1,914,623	0	54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0.363362	0	169,880	0	54.01
56.00 05600 RADIOISOTOPE	0.332772	0	259,162	0	56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143903	0	277,641	0	58.00
60.00 06000 LABORATORY	0.277244	0	2,968,855	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862014	0	29,179	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.065020	0	86,491	0	64.00
66.00 06600 PHYSICAL THERAPY	0.605128	0	531,255	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.737400	0	57,757	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.454679	0	508	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01 03160 CARDIOPULMONARY	0.503170	0	744,669	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553159	0	184,042	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.894797	0	393,217	0	73.00
76.00 03020 OP SENIOR HEALTH	0.546405	0	1,295,387	0	76.00
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.304437	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				88.01
91.00 09100 EMERGENCY	1.391976	0	512,401	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.905337	0	65,593	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.346468		0		95.00
200.00	Subtotal (see instructions)	0	10,189,105	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	10,189,105	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/14/2013 4:25 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	273,479	0	50.00
53.00	05300	ANESTHESIOLOGY	0	172,492	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	510,329	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	61,728	0	54.01
56.00	05600	RADIOISOTOPE	0	86,242	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	39,953	0	58.00
60.00	06000	LABORATORY	0	823,097	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,153	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	5,624	0	64.00
66.00	06600	PHYSICAL THERAPY	0	321,477	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,590	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	739	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	374,695	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101,804	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	351,849	0	73.00
76.00	03020	OP SENIOR HEALTH	0	707,806	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
91.00	09100	EMERGENCY	0	713,250	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	59,384	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	4,671,691	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	4,671,691	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313 Component CCN: 14Z313	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/14/2013 4:25 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see inst.)	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	0.670370	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.593793	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.266543	0	0	0	54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0.363362	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.332772	0	0	0	56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143903	0	0	0	58.00
60.00 06000 LABORATORY	0.277244	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862014	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.065020	0	0	0	64.00
66.00 06600 PHYSICAL THERAPY	0.605128	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.737400	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.454679	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01 03160 CARDIOPULMONARY	0.503170	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553159	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.894797	0	0	0	73.00
76.00 03020 OP SENIOR HEALTH	0.546405	0	0	0	76.00
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.304437	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				88.01
91.00 09100 EMERGENCY	1.391976	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.905337	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.346468		0		95.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141313	Period: From 10/01/2011	Worksheet D Part V Date/Time Prepared: 2/14/2013 4:25 pm
		Component CCN: 14Z313	To 09/30/2012	
Title XVIII			Swing Beds - SNF	Cost

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
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
69.01	03160	CARDIOPULMONARY	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/14/2013 4:25 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,576	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		982	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.		13	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		826	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		149	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)		445	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)		652	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)		144	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)		432	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)		5	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		119.88	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		119.88	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,641,469	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)		995,580	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,645,889	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,036,850	28.00
29.00	Private room charges (excluding swing-bed charges)		20,865	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,015,985	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.587394	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,605.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,230.01	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		374.99	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		595.26	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		7,738	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,638,151	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)		1,668.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,087,653	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		2,976	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,090,629	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/14/2013 4:25 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					714,545	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,805,174	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					240,218	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					720,654	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					960,872	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)					143	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,676.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					239,677	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/14/2013 4:25 pm	
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: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/14/2013 4:25 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		880,514		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.670370	81,180	54,421	50.00
53.00	05300 ANESTHESIOLOGY	0.593793	54,213	32,191	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.266543	162,061	43,196	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.363362	26,601	9,666	54.01
56.00	05600 RADIOISOTOPE	0.332772	7,314	2,434	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.143903	35,695	5,137	58.00
60.00	06000 LABORATORY	0.277244	387,411	107,407	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862014	26,342	22,707	62.00
64.00	06400 INTRAVENOUS THERAPY	0.065020	26,852	1,746	64.00
66.00	06600 PHYSICAL THERAPY	0.605128	55,851	33,797	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.737400	36,300	26,768	67.00
68.00	06800 SPEECH PATHOLOGY	1.454679	1,562	2,272	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	0.503170	214,583	107,972	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553159	161,968	89,594	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.894797	195,273	174,730	73.00
76.00	03020 OP SENIOR HEALTH	0.546405	0	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.304437	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	1.391976	364	507	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.905337	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,473,570	714,545	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,473,570		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141313	Period: From 10/01/2011	Worksheet D-3	
		Component CCN: 14Z313	To 09/30/2012	Date/Time Prepared: 2/14/2013 4:25 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
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.670370	0	50.00
53.00	05300	ANESTHESIOLOGY	0.593793	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266543	29,444	7,848 54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.363362	4,182	1,520 54.01
56.00	05600	RADIOISOTOPE	0.332772	0	0 56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.143903	3,293	474 58.00
60.00	06000	LABORATORY	0.277244	112,518	31,195 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.862014	8,358	7,205 62.00
64.00	06400	INTRAVENOUS THERAPY	0.065020	7,908	514 64.00
66.00	06600	PHYSICAL THERAPY	0.605128	126,229	76,385 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.737400	113,444	83,654 67.00
68.00	06800	SPEECH PATHOLOGY	1.454679	2,276	3,311 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
69.01	03160	CARDIOPULMONARY	0.503170	83,405	41,967 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553159	49,140	27,182 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.894797	121,713	108,908 73.00
76.00	03020	OP SENIOR HEALTH	0.546405	0	0 76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.304437	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0 88.01
91.00	09100	EMERGENCY	1.391976	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.905337	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0 93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		661,910	390,163 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		661,910	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/14/2013 4:25 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,671,691 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)			4,671,691 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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			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)			4,718,408 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)			42,170 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,433,089 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)			3,243,149 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)			3,243,149 30.00
31.00	Primary payer payments			123 31.00
32.00	Subtotal (line 30 minus line 31)			3,243,026 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)			368,001 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			368,001 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			345,250 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,611,027 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)			3,611,027 40.00
41.00	Interim payments			3,761,202 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)			-150,175 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: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/14/2013 4:25 pm
		Title XVIII	Hospital Cost
			Overrides
WORKSHEET OVERRIDE VALUES			1.00
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141313

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

Worksheet E-1
Part I
Date/Time Prepared:
2/14/2013 4:25 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		1,506,580		3,761,202	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	05/01/2012	154,000		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)		154,000		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,660,580		3,761,202	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		13,136		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		150,175	6.02	
7.00	Total Medicare program liability (see instructions)		1,673,716		3,611,027	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: 141313
Component CCN: 14Z313

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

Worksheet E-1
Part I
Date/Time Prepared:
2/14/2013 4:25 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		1,265,591		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	05/01/2012	123,400		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)		123,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,388,991		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		35,283		0	6.02
7.00	Total Medicare program liability (see instructions)		1,353,708		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141313

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

Worksheet E-1
Part II
Date/Time Prepared:
2/14/2013 4:25 pm

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			310	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			652	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			19	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			839	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			31,339,329	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			454,363	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			654,917	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			654,917	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			654,917	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment			0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141313

Period:

Worksheet E-2

Component CCN: 14Z313

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

Date/Time Prepared:
2/14/2013 4:25 pm

		Title XVIII		Swing Beds - SNF	
		Cost			
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	970,481	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)	394,065	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	576	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)	1,364,546	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,364,546	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)	1,364,546	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,838	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)	1,353,708	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)	1,353,708	0	19.00	
20.00	Interim payments	1,388,991	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)	-35,283	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: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/14/2013 4:25 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			1,805,174 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)			1,805,174 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,823,226 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)			1,823,226 19.00
20.00	Deductibles (exclude professional component)			192,044 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,631,182 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,631,182 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			42,534 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			42,534 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			37,340 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,673,716 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,673,716 30.00
31.00	Interim payments			1,660,580 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)			13,136 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 141313

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

Worksheet G

Date/Time Prepared:
2/14/2013 4:25 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	2,459,238	0	0	0	1.00
2.00	Temporary investments	469,332	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,273,536	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	365,671	0	0	0	7.00
8.00	Prepaid expenses	116,597	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,684,374	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,627,652	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,627,652	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,377,542	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	453,415	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,830,957	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,142,983	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,413,447	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,172,124	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	710,453	0	0	0	40.00
41.00	Deferred income	700,875	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	270,713	0	0	0	43.00
44.00	Other current liabilities	449,084	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,716,696	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,960,851	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	362,173	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,323,024	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,039,720	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,103,263				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,103,263	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,142,983	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141313

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

Worksheet G-1

Date/Time Prepared:
2/14/2013 4:25 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		7,910,668		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,192,518			2.00
3.00	Total (sum of line 1 and line 2)		9,103,186		0	3.00
4.00	ROUNDING	77		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		77		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,103,263		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,103,263		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141313

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

Worksheet G-1

Date/Time Prepared:
2/14/2013 4:25 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141313

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,935,729		1,935,729	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,935,729		1,935,729	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,935,729		1,935,729	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	0	1	1	19.00
20.00	RURAL HEALTH CLINIC	0	2,891,498	2,891,498	20.00
20.01	RURAL HEALTH CLINIC II	0	240,409	240,409	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,529,293	1,529,293	22.00
23.00	AMBULANCE SERVICES	2,177	1,412,982	1,415,159	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OPERATING ROOM	166,704	1,000,636	1,167,340	27.01
27.02	ANESTHESIOLOGY	78,929	677,047	755,976	27.02
27.03	RADIOLOGY-DIAGNOSTIC	246,160	4,598,750	4,844,910	27.03
27.04	RADIOLOGY-ULTRASOUND	37,936	411,597	449,533	27.04
27.05	RADIOISOTOPE	14,960	602,069	617,029	27.05
27.06		0	0	0	27.06
27.07	MRI	48,531	988,193	1,036,724	27.07
27.08	LABORATORY	670,608	5,817,240	6,487,848	27.08
27.09		0	0	0	27.09
27.10	INTRAVENOUS THERAPY	86,023	229,020	315,043	27.10
27.11	PHYSICAL THERAPY	360,345	1,448,226	1,808,571	27.11
27.12		0	0	0	27.12
27.13	CARDIOPULMONARY	476,277	1,623,413	2,099,690	27.13
27.14	MEDICAL SUPPLIES CHARGED	54,828	150,135	204,963	27.14
27.15		0	0	0	27.15
27.16	DRUGS CHARGED TO PATIENTS	375,709	712,331	1,088,040	27.16
27.17	OP SENIOR PSYCH	0	1,313,216	1,313,216	27.17
27.18	TELEMEDICINE PSYCH	0	56,350	56,350	27.18
27.19		0	0	0	27.19
27.20		0	0	0	27.20
27.21	EMERGENCY	68,494	3,819,295	3,887,789	27.21
27.22		0	0	0	27.22
27.23		0	0	0	27.23
27.24		0	0	0	27.24
27.25		0	0	0	27.25
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,623,411	29,521,702	34,145,113	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,309,082		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	EMPLOYEE PHYSICALS	1,378			38.00
39.00	PHARMACIST REIMBURSE	1,125			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,503		42.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141313

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Wkst. G-3, line 4)		21,306,579		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141313

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

Worksheet G-3

Date/Time Prepared:
2/14/2013 4:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,145,113	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,975,102	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,170,011	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,306,579	4.00
5.00	Net income from service to patients (line 3 minus line 4)	863,432	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	545,949	6.00
7.00	Income from investments	113,034	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	840,002	23.00
24.00	OTHER REVENUE	432,046	24.00
24.01	GRANT REVENUE	14,419	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	693,000	24.02
24.03	CAPITAL GRANT	113,263	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	2,751,713	25.00
26.00	Total (line 5 plus line 25)	3,615,145	26.00
27.00	BAD DEBTS	1,968,263	27.00
27.01	CHARITY CARE	454,364	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,422,627	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,192,518	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313

Period: From 10/01/2011

Worksheet H

HHA CCN: 147202

To 09/30/2012

Date/Time Prepared: 2/14/2013 4:25 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	54,885	3,848	41,158	0	36,173	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	457,324	32,066	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	856	60	0	0	0	10.00
11.00	Home Health Aide	15,163	1,063	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	528,228	37,037	41,158	0	36,173	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313

Period:

Worksheet H

HHA CCN: 147202

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

Date/Time Prepared:
2/14/2013 4:25 pm

Home Health
Agency I

PPS

	Total (sum of col. 1 thru 5)	Recl ass i f i c a t i o n	Recl ass i f i e d Tri al B a l a n c e (col. 6 + col. 7)	Adj u s t m e n t s	Net Expenses for Al l o c a t i o n (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	136,064	0	136,064	-128	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	489,390	0	489,390	0	6.00
7.00	Physical Therapy	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	9.00
10.00	Medical Social Services	916	0	916	0	10.00
11.00	Home Health Aide	16,226	0	16,226	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	642,596	0	642,596	-128	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 141313	Period:	Worksheet H-1
	HHA CCN: 147202	From 10/01/2011 To 09/30/2012	Part I Date/Time Prepared: 2/14/2013 4:25 pm
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	135,936	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	489,390	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	9.00
10.00	Medical Social Services	916	0	0	0	10.00
11.00	Home Health Aide	16,226	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	642,468	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141313	Period:	Worksheet H-1
		HHA CCN: 147202	From 10/01/2011	Part I
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	Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
	4A.00	5.00	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	135,936	135,936	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	489,390	131,335	620,725
7.00	Physical Therapy	0	0	0
8.00	Occupational Therapy	0	0	0
9.00	Speech Pathology	0	0	0
10.00	Medical Social Services	916	246	1,162
11.00	Home Health Aide	16,226	4,355	20,581
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	642,468		642,468

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 141313 HHA CCN: 147202		Period: From 10/01/2011 To 09/30/2012		Worksheet H-1 Part II Date/Time Prepared: 2/14/2013 4:25 pm	
				Home Health Agency I		PPS	
		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-135,936	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-135,936	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 141313	Period:	Worksheet H-1
	HHA CCN: 147202	From 10/01/2011 To 09/30/2012	Part II Date/Time Prepared: 2/14/2013 4:25 pm
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		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	506,532	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	489,390	6.00
7.00	Physical Therapy	0	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	916	10.00
11.00	Home Health Aide	16,226	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	506,532	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	135,936	25.00
26.00	Unit Cost Multiplier	0.268366	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147202

To 09/30/2012

Part I
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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW MVBLE EQUIP	
1.00 Administrative and General	0	0	5,766	0	7,992	1.00
2.00 Skilled Nursing Care	620,725	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	1,162	0	0	0	0	6.00
7.00 Home Health Aide	20,581	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	642,468	0	5,766	0	7,992	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

Worksheet H-2

HHA CCN: 147202

From 10/01/2011
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Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		4.00	4A	5.01	5A.01	5.02	
1.00	Administrative and General	94,967	108,725	14,692	123,417	0	1.00
2.00	Skilled Nursing Care	0	620,725	83,876	704,601	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	1,162	157	1,319	0	6.00
7.00	Home Health Aide	0	20,581	2,781	23,362	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	94,967	751,193	101,506	852,699	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000		0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

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HHA CCN: 147202

From 10/01/2011
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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.00	7.00	7.01	8.00	9.00	
1.00	Administrative and General	13,777	0	0	43	10,737	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	13,777	0	0	43	10,737	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147202

To 09/30/2012

Part I
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Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	14,241	0	162,215	0	162,215	1.00
2.00	Skilled Nursing Care	0	0	704,601	0	704,601	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	1,319	0	1,319	6.00
7.00	Home Health Aide	0	0	23,362	0	23,362	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	14,241	0	891,497	0	891,497	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141313	Period: From 10/01/2011	Worksheet H-2
		HHA CCN: 147202	To 09/30/2012	Part I
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Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	156,726	861,327	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	293	1,612	6.00
7.00	Home Health Aide	5,196	28,558	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	162,215	891,497	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.222431		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313

HHA CCN: 147202

Period:

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

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Part II
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Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
	1.00	1.01	1.02	2.00		
1.00 Administrative and General	0	1,594	0	8,289	528,228	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	1,594	0	8,289	528,228	20.00
21.00 Total cost to be allocated	0	5,766	0	7,992	94,967	21.00
22.00 Unit cost multiplier	0.000000	3.617315	0.000000	0.964169	0.179784	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313
HHA CCN: 147202

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

Worksheet H-2
Part II
Date/Time Prepared:
2/14/2013 4:25 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	
1.00	Administrative and General	0	108,725	-123,417	0	1,594	1.00
2.00	Skilled Nursing Care	0	620,725	-704,601	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	1,162	-1,319	0	0	6.00
7.00	Home Health Aide	0	20,581	-23,362	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)		751,193		0	1,594	20.00
21.00	Total cost to be allocated		101,506		0	13,777	21.00
22.00	Unit cost multiplier		0.135126		0.000000	8.643036	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313
HHA CCN: 147202

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

Worksheet H-2
Part II
Date/Time Prepared:
2/14/2013 4:25 pm
PPS

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	7.00	7.01	8.00	9.00	10.00	
1.00 Administrative and General	0	0	28	1,594	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	28	1,594	0	20.00
21.00 Total cost to be allocated	0	0	43	10,737	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	1.535714	6.735885	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147202		Date/Time Prepared: 2/14/2013 4:25 pm
		Home Health Agency I	PPS

Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENT)	PHARMACY (COSTED REQUIREMENT)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	0	1,529,267	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	1,529,267	20.00
21.00 Total cost to be allocated	0	0	0	0	14,241	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.009312	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141313	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147202	Home Health Agency I	Date/Time Prepared: 2/14/2013 4:25 pm PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141313 HHA CCN: 147202		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-II Date/Time Prepared: 2/14/2013 4:25 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	861,327		861,327	30,249	1.00
2.00	Physical Therapy	3.00	0	278,516	278,516	3,176	2.00
3.00	Occupational Therapy	4.00	0	0	0	1,688	3.00
4.00	Speech Pathology	5.00	0	0	0	67	4.00
5.00	Medical Social Services	6.00	1,612		1,612	36	5.00
6.00	Home Health Aide	7.00	28,558		28,558	870	6.00
7.00	Total (sum of lines 1-6)		891,497	278,516	1,170,013	36,086	7.00
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	2,053	1,831		8.00
9.00	Physical Therapy		99914	710	390		9.00
10.00	Occupational Therapy		99914	394	192		10.00
11.00	Speech Pathology		99914	18	0		11.00
12.00	Medical Social Services		99914	6	10		12.00
13.00	Home Health Aide		99914	173	119		13.00
14.00	Total (sum of lines 8-13)			3,354	2,542		14.00
				Total HHA Costs (cols. 1 + 2)		Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	8,075	15.00
16.00	Cost of Drugs	9.00	0	0	0	1,069	16.00
				Total HHA Charge (from provider records)		HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.605128	460,259	278,516	1.00
2.00	Occupational Therapy		67.00	0.737400	0	0	2.00
3.00	Speech Pathology		68.00	1.454679	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.553159	0	0	4.00
5.00	Cost of Drugs		73.00	0.894797	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313

Period: From 10/01/2011

Worksheet H-3

HHA CCN: 147202

To 09/30/2012

Parts I-III
Date/Time Prepared:
2/14/2013 4:25 pm

Title XVIII

Home Health Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	28.47	2,053	1,831		1.00
2.00	Physical Therapy	87.69	710	390		2.00
3.00	Occupational Therapy	0.00	394	192		3.00
4.00	Speech Pathology	0.00	18	0		4.00
5.00	Medical Social Services	44.78	6	10		5.00
6.00	Home Health Aide	32.83	173	119		6.00
7.00	Total (sum of lines 1-6)		3,354	2,542		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		0	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy	col. 2, line 3.00				2.00
3.00	Speech Pathology	col. 2, line 4.00				3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141313 HHA CCN: 147202		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 2/14/2013 4:25 pm	
		Title XVII		Home Health Agency I		PPS	
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
9.00	10.00	11.00	12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	58,449	52,129	110,578	1.00		
2.00	Physical Therapy	62,260	34,199	96,459	2.00		
3.00	Occupational Therapy	0	0	0	3.00		
4.00	Speech Pathology	0	0	0	4.00		
5.00	Medical Social Services	269	448	717	5.00		
6.00	Home Health Aide	5,680	3,907	9,587	6.00		
7.00	Total (sum of lines 1-6)	126,658	90,683	217,341	7.00		
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care				8.00		
9.00	Physical Therapy				9.00		
10.00	Occupational Therapy				10.00		
11.00	Speech Pathology				11.00		
12.00	Medical Social Services				12.00		
13.00	Home Health Aide				13.00		
14.00	Total (sum of lines 8-13)				14.00		
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies				15.00		
16.00	Cost of Drugs		0	0	16.00		

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 141313 HHA CCN: 147202	Period: From 10/01/2011 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/14/2013 4:25 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		402,979	313,878
12.00	Total PPS Reimbursement - Full Episodes with Outliers		14,615	6,818
13.00	Total PPS Reimbursement - LUPA Episodes		4,321	5,744
14.00	Total PPS Reimbursement - PEP Episodes		963	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		4,238	2,100
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	460
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		427,116	329,000
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		427,116	329,000
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		427,116	329,000
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		427,116	329,000
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		427,116	329,000
32.00	Interim payments (see instructions)		427,116	329,000
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141313
HHA CCN: 147202

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

Worksheet H-5
Date/Time Prepared:
2/14/2013 4:25 pm
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		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		427,116		329,000	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		427,116		329,000	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		427,116		329,000	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/14/2013 4:25 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,372,270	0	1,372,270	-88,311	1,283,959	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	283,924	0	283,924	0	283,924	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	594,755	0	594,755	0	594,755	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,250,949	0	2,250,949	-88,311	2,162,638	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	24,288	24,288	0	24,288	13.00
14.00	Subtotal (sum of lines 11-13)	0	24,288	24,288	0	24,288	14.00
15.00	Medical Supplies	0	21,250	21,250	0	21,250	15.00
16.00	Transportation (Health Care Staff)	0	333	333	0	333	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	118,298	118,298	0	118,298	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	139,881	139,881	0	139,881	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,250,949	164,169	2,415,118	-88,311	2,326,807	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	6,598	6,598	0	6,598	29.00
30.00	Administrative Costs	286,028	397,679	683,707	0	683,707	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	286,028	404,277	690,305	0	690,305	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,536,977	568,446	3,105,423	-88,311	3,017,112	32.00

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

Provider CCN: 141313
Component CCN: 143457

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

Worksheet M-1
Date/Time Prepared:
2/14/2013 4:25 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	1,283,959	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	283,924	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	594,755	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	2,162,638	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	24,288	13.00
14.00	Subtotal (sum of lines 11-13)	0	24,288	14.00
15.00	Medical Supplies	0	21,250	15.00
16.00	Transportation (Health Care Staff)	0	333	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	118,298	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	139,881	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,326,807	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	6,598	29.00
30.00	Administrative Costs	-2,803	680,904	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,803	687,502	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,803	3,014,309	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/14/2013 4:25 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	52,420	0	52,420	0	52,420	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	92,885	0	92,885	0	92,885	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	14,331	0	14,331	0	14,331	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	159,636	0	159,636	0	159,636	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	2,013	2,013	0	2,013	13.00
14.00	Subtotal (sum of lines 11-13)	0	2,013	2,013	0	2,013	14.00
15.00	Medical Supplies	0	885	885	0	885	15.00
16.00	Transportation (Health Care Staff)	0	8,570	8,570	0	8,570	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	9,455	9,455	0	9,455	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	159,636	11,468	171,104	0	171,104	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	10,429	10,429	0	10,429	29.00
30.00	Administrative Costs	75,861	39,213	115,074	0	115,074	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	75,861	49,642	125,503	0	125,503	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	235,497	61,110	296,607	0	296,607	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/14/2013 4:25 pm
		Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	52,420
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	92,885
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	14,331
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	159,636
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	2,013
14.00	Subtotal (sum of lines 11-13)	0	2,013
15.00	Medical Supplies	0	885
16.00	Transportation (Health Care Staff)	0	8,570
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	9,455
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	171,104
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	10,429
30.00	Administrative Costs	-1,020	114,054
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,020	124,483
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,020	295,587

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES			Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/14/2013 4:25 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	3.33	11,099	4,200	13,986	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.87	6,550	2,100	6,027	3.00
4.00	Subtotal (sum of lines 1-3)	6.20	17,649		20,013	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	6.20	17,649		20,013	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				2,326,807	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)				2,326,807	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)				687,502	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,295,627	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,983,129	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				1,983,129	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,983,129	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				4,309,936	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/14/2013 4:25 pm
			Rural Health Clinic (RHC) II	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.39	1,073	4,200	1,638	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.11	1,341	2,100	2,331	3.00
4.00	Subtotal (sum of lines 1-3)	1.50	2,414		3,969	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.50	2,414		3,969	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				171,104	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)				171,104	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)				124,483	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				91,465	15.00
16.00	Total overhead (sum of lines 14 and 15)				215,948	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				215,948	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				215,948	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				387,052	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3 Date/Time Prepared: 2/14/2013 4:25 pm
		Title XVIIII	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)		4,309,936	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,309,936	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		20,013	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)		20,013	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.36	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	215.36	215.36	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,266	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,134,086	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	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,134,086	16.00
16.01	Total program charges (see instructions)(from contractor's records)		769,056	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,205	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,251	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.)		851,244	16.04
16.05	Total program cost (see instructions)		854,495	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		66,780	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		854,495	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		854,495	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		854,495	26.00
27.00	Interim payments		651,244	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)		203,251	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3 Date/Time Prepared: 2/14/2013 4:25 pm
		Title XVIIII	Rural Health Clinic (RHC) II	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)		387,052	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		387,052	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,969	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)		3,969	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		97.52	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	97.52	97.52	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	342	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	33,352	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	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		33,352	16.00
16.01	Total program charges (see instructions)(from contractor's records)		49,416	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.)		22,311	16.04
16.05	Total program cost (see instructions)		22,311	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,463	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		22,311	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		22,311	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		22,311	26.00
27.00	Interim payments		25,244	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)		-2,933	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/14/2013 4:25 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		651,244	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		651,244	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		203,251	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		854,495	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/14/2013 4:25 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		25,244	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		25,244	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,933	6.02
7.00	Total Medicare program liability (see instructions)		22,311	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00