

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 2/24/2014 8:45 am
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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 checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/24/2014 Time: 8:45 am
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 MIDWEST MEDICAL CENTER (141302) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/24/2014 Time: 8:45 am
 VXLGjthyd7mE4mnqbxds.ZeYJBAFV0
 ZBW5A0pecS3Tm40rk.SA4cpGWSu:hm
 gjMp0VgwF10HYBw:
 PI: Date: 2/24/2014 Time: 8:45 am
 Y6mvut100k7Kqpgzqon1sI1aHoHa0
 S1Vjf0K7:dEz4di0ZFdDqtjBs6RXJ6
 7n0Y0SX1YS04lad4

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	182,215	-75,976	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	161,486	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	-236	0		0	7.00
10.00 RURAL HEALTH CLINIC I	0		26,067		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	343,465	-49,909	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/24/2014 8:43 am			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1 MEDICAL CENTER DRIVE		PO Box:						
2.00	City: GALENA		State: IL		Zip Code: 61036-		County: JO DAVIESS		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
							V	XVIII	XIX
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF	MIDWEST MEDICAL CENTER	142302	99914		02/01/2000	N	O	N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF	GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC	MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2012	09/30/2013		20.00
21.00	Type of Control (see instructions)					2			21.00
Inpatient PPS Information									
22.00	Does this facility qualify 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	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N	
		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		
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		
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/24/2014 8:43 am			
		Beginning: 1.00	Ending: 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N 1.00	Y/N 2.00				
39.00	Does 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. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00	
		V 1.00	XVIII 2.00	XIX 3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/24/2014 8:43 am	
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01		
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00			0.000000	67.00
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	76.00
					1.00			
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.						N	80.00
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						N	85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00
					V	XIX		
					1.00	2.00		
Title V and XIX Services								
90.00	Does this facility have title v and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N		Y	90.00
91.00	Is this hospital reimbursed for title v and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						Y	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title v and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N		N	93.00
94.00	Does title v or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00
96.00	Does title v or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00
Rural Providers								
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				Y			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/24/2014 8:43 am		
			V 1.00	XIX 2.00		
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	26,954	0	0		118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
2/24/2014 8:43 am

		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:	PO Box:					142.00	
143.00	City:	State:		Zip Code:			143.00	
							1.00	
144.00	Are provider based physicians' costs included in worksheet A?						Y	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N	145.00
							1.00	
							2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	Y	Y	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
161.10	CORF		N	N	N		161.10	
							1.00	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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
		Beginning		Ending				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141302		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part II Date/Time Prepared: 2/24/2014 8:44 am	
		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	01/31/2014			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	Attachment A				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 the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N					9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N					11.00
			Y/N				
			1.00				
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Exhibit 5	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
	Description	Y/N	Date	Y/N			
	0	1.00	2.00	3.00			
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N				N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/19/2014			Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N				N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N				N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N				N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAUL		TRACZEK	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	7158586619		PTRACZEK@WIPFLI.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	02/19/2014	Attachments D-G	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CPA / SENIOR MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part V
Date/Time Prepared:
2/24/2014 8:44 am

1.00

Cost Report Preparer Contact Information

1.00	First Name	PAUL	1.00
2.00	Last Name	TRACZEK	2.00
3.00	Title	CPA	3.00
4.00	Employer	WIPFLI LLP	4.00
5.00	Phone Number	(715)858-6619	5.00
6.00	E-mail Address	PTRACZEK@WIPFLI.COM	6.00
7.00	Department	HEALTHCARE	7.00
8.00	Mailing Address 1	3703 OAKWOOD HILLS PKWY / PO BOX 690	8.00
9.00	Mailing Address 2		9.00
10.00	City	EAU CLAIRE	10.00
11.00	State	WI	11.00
12.00	Zip	54701	12.00

Officer or Administrator of Provider Contact Information

13.00	First Name	TRACY	13.00
14.00	Last Name	BAUER	14.00
15.00	Title	CHIEF EXECUTIVE OFFICER	15.00
16.00	Employer	MIDWEST MEDICAL CENTER	16.00
17.00	Phone Number	(815)776-7266	17.00
18.00	E-mail Address	TBAUER@GALENAHEALTH.ORG	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	ONE MEDICAL CENTER DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	GALENA	22.00
23.00	State	IL	23.00
24.00	Zip	61036	24.00

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/24/2014 8:43 am

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	
	Line Number		Available		Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	10,161.05	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	10,161.05	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	10,161.05	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,825		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	18,980			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	332	9	415			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,027	0	1,052			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		9	185			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,359	18	1,652			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)	1,359	18	1,652	0.00	89.18	14.00
15.00 CAH visits	4,989	0	18,031			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	112	0	112	0.00	3.10	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			18,497	0.00	45.57	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	2,636	0	9,924	0.00	13.65	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	151.50	27.00
28.00 Observation Bed Days		0	138			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		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)(see instructions for col. 2 for the portion of LDP room available beds)		0	125	3	159	1.00
2.00 HMO and other (see instructions)			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	0	125	3	159	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				47	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Provider CCN: 141302

Period:
 From 10/01/2012
 To 09/30/2013

Worksheet S-7

Date/Time Prepared:
 2/24/2014 8:43 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	02/01/2000	2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
	1.00	2.00	3.00	4.00
3.00	RUX	0	0	0 3.00
4.00	RUL	0	0	0 4.00
5.00	RVX	0	0	0 5.00
6.00	RVL	0	0	0 6.00
7.00	RHX	0	0	0 7.00
8.00	RHL	0	0	0 8.00
9.00	RMX	0	0	0 9.00
10.00	RML	14	0	14 10.00
11.00	RLX	0	0	0 11.00
12.00	RUC	0	0	0 12.00
13.00	RUB	0	0	0 13.00
14.00	RUA	0	0	0 14.00
15.00	RVC	0	0	0 15.00
16.00	RVB	15	0	15 16.00
17.00	RVA	0	0	0 17.00
18.00	RHC	14	0	14 18.00
19.00	RHB	0	0	0 19.00
20.00	RHA	5	0	5 20.00
21.00	RMC	0	0	0 21.00
22.00	RMB	0	0	0 22.00
23.00	RMA	46	0	46 23.00
24.00	RLB	0	0	0 24.00
25.00	RLA	8	0	8 25.00
26.00	ES3	0	0	0 26.00
27.00	ES2	0	0	0 27.00
28.00	ES1	0	0	0 28.00
29.00	HE2	0	0	0 29.00
30.00	HE1	0	0	0 30.00
31.00	HD2	0	0	0 31.00
32.00	HD1	0	0	0 32.00
33.00	HC2	0	0	0 33.00
34.00	HC1	0	0	0 34.00
35.00	HB2	0	0	0 35.00
36.00	HB1	0	0	0 36.00
37.00	LE2	0	0	0 37.00
38.00	LE1	0	0	0 38.00
39.00	LD2	0	0	0 39.00
40.00	LD1	0	0	0 40.00
41.00	LC2	0	0	0 41.00
42.00	LC1	5	0	5 42.00
43.00	LB2	0	0	0 43.00
44.00	LB1	0	0	0 44.00
45.00	CE2	0	0	0 45.00
46.00	CE1	0	0	0 46.00
47.00	CD2	0	0	0 47.00
48.00	CD1	0	0	0 48.00
49.00	CC2	0	0	0 49.00
50.00	CC1	0	0	0 50.00
51.00	CB2	0	0	0 51.00
52.00	CB1	0	0	0 52.00
53.00	CA2	0	0	0 53.00
54.00	CA1	0	0	0 54.00
55.00	SE3	0	0	0 55.00
56.00	SE2	0	0	0 56.00
57.00	SE1	0	0	0 57.00
58.00	SSC	0	0	0 58.00
59.00	SSB	0	0	0 59.00
60.00	SSA	0	0	0 60.00
61.00	IB2	0	0	0 61.00
62.00	IB1	0	0	0 62.00
63.00	IA2	0	0	0 63.00
64.00	IA1	0	0	0 64.00
65.00	BB2	0	0	0 65.00
66.00	BB1	0	0	0 66.00
67.00	BA2	0	0	0 67.00
68.00	BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-7

Date/Time Prepared:
2/24/2014 8:43 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		112	0	112	200.00

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

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	6,738	10.46	N	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	64,400			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/24/2014 8:43 am
		Rural Health Clinic (RHC) I	Cost

			1.00	
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1.00	Clinic Address and Identification			1.00
	Street	ONE MEDICAL CENTER DRIVE		1.00

		City	State	Zip Code
		1.00	2.00	3.00

2.00	City, State, Zip Code, County	GALENA	IL	61036	2.00
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3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		1.00	0	3.00
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		Grant Award	Date
		1.00	2.00

Source of Federal Funds			
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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	
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10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00
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		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00

11.00	Facility hours of operations (1)				
	Clinic	08:00	17:00	08:00	11.00

		1.00	2.00
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12.00	Have you received an approval for an exception to the productivity standard?	Y	12.00
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13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, 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	13.00
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		Provider name		CCN number
		1.00		2.00

14.00	Provider name, CCN number				14.00
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		Y/N	V	XVIII	XIX	Total visits
		1.00	2.00	3.00	4.00	5.00

15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	0	0	0	0	0	15.00
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-8
Date/Time Prepared:
2/24/2014 8:43 am

				Rural Health Clinic (RHC) I		Cost
		County				
		4.00				
2.00	City, State, Zip Code, County	JO DAVIESS				2.00
		Tuesday		Wednesday		Thursday
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	12:00	11.00

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.871982	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,910,631	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	4,068,187	6.00
7.00	Medicaid cost (line 1 times line 6)	3,547,386	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,636,755	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
Uncompensated care (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,636,755	19.00
		Uninsured patients	Insured patients
		1.00	2.00
			Total (col. 1 + col. 2)
			3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	232,267	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	202,533	0
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	202,533	0
			1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	505,327	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	19,286	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	486,041	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	423,819	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	626,352	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,263,107	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,668,420	1,668,420	-1,542,939	125,481	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0	0	114,118	114,118	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0	0	4,169,765	4,169,765	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		612,632	612,632	-555,082	57,550	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	963,925	963,925	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		0	1,548,806	-107,764	1,441,042	4.00
5.01	00510	ADMITTING	182,529	4,827	187,356	0	187,356	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	558,791	1,006,893	1,565,684	-234,264	1,331,420	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	48,244	607,004	655,248	-90,146	565,102	7.00
7.01	00701	OPERATION OF PLANT-SCC	68,145	110,915	179,060	90,146	269,206	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,700	93,700	-39,783	53,917	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	39,783	39,783	8.01
9.00	00900	HOUSEKEEPING	102,962	488	103,450	0	103,450	9.00
9.01	00901	HOUSEKEEPING-SCC	68,969	144	69,113	0	69,113	9.01
10.00	01000	DIETARY	163,017	103,747	266,764	0	266,764	10.00
10.01	01001	DIETARY-SCC	200,482	223,163	423,645	111,114	534,759	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	150,006	14,813	164,819	36,171	200,990	13.00
15.00	01500	PHARMACY	0	0	0	108,000	108,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,717	7,700	109,417	0	109,417	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	541,315	66,534	607,849	87,537	695,386	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	28,616	28,616	44.00
46.00	04600	OTHER LONG TERM CARE	1,119,552	157,187	1,276,739	165,279	1,442,018	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	111,550	176,309	287,859	6,040	293,899	50.00
53.00	05300	ANESTHESIOLOGY	0	70,800	70,800	0	70,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,944	653,720	919,664	20,098	939,762	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	240,009	375,901	615,910	0	615,910	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	27,605	27,605	0	27,605	64.00
65.00	06500	RESPIRATORY THERAPY	0	21,831	21,831	0	21,831	65.00
66.00	06600	PHYSICAL THERAPY	587,748	84,987	672,735	-19,200	653,535	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,142	53,142	9,359	62,501	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,749	4,749	0	4,749	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,110	82,089	144,199	0	144,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	316,644	316,644	-98,950	217,694	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	8,273	8,273	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,281,531	187,110	1,468,641	-27,536	1,441,105	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	239,854	1,231,538	1,471,392	0	1,471,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	3,125,134	3,125,134	-3,083,986	41,148	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,094,475	12,638,532	18,733,007	158,574	18,891,581	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	78,390	78,390	-51,112	27,278	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	212,027	124,720	336,747	-88,598	248,149	194.01
194.02	07952	ADULT DAY CARE	94,111	46,854	140,965	-28,705	112,260	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	9,841	9,841	194.05
200.00		TOTAL (SUM OF LINES 118-199)	6,400,613	12,888,496	19,289,109	0	19,289,109	200.00

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	0	125,481	1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG	0	114,118	1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL	-29,788	4,139,977	1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-907	56,643	2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-5,372	958,553	2.01
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1,441,042	4.00
5.01	00510 ADMITTING	0	187,356	5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL	-62,152	1,269,268	5.02
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	-5,824	559,278	7.00
7.01	00701 OPERATION OF PLANT-SCC	0	269,206	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	53,917	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	39,783	8.01
9.00	00900 HOUSEKEEPING	0	103,450	9.00
9.01	00901 HOUSEKEEPING-SCC	0	69,113	9.01
10.00	01000 DIETARY	0	266,764	10.00
10.01	01001 DIETARY-SCC	-96,575	438,184	10.01
11.00	01100 CAFETERIA	-63,810	-63,810	11.00
11.01	01101 CAFETERIA-SCC	-65,789	-65,789	11.01
13.00	01300 NURSING ADMINISTRATION	0	200,990	13.00
15.00	01500 PHARMACY	0	108,000	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2,456	106,961	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-11,739	683,647	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	28,616	44.00
46.00	04600 OTHER LONG TERM CARE	-70,482	1,371,536	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-44,305	249,594	50.00
53.00	05300 ANESTHESIOLOGY	0	70,800	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-227,242	712,520	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	615,910	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	27,605	64.00
65.00	06500 RESPIRATORY THERAPY	0	21,831	65.00
66.00	06600 PHYSICAL THERAPY	0	653,535	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	62,501	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,749	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	144,199	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	217,694	73.00
76.00	03020 SLEEP LAB	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,273	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-10,775	1,430,330	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	-178,428	1,292,964	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
113.00	11300 INTEREST EXPENSE	-41,148	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-916,792	17,974,789	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	27,278	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951 ASSISTED LIVING UNITS	0	248,149	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.02	07952 ADULT DAY CARE	0	112,260	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954 IDLE SPACE	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	9,841	194.05
200.00	TOTAL (SUM OF LINES 118-199)	-916,792	18,372,317	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet Non-CMS W

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-ALU BLDG	00101		1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	00102		1.02
1.03	NEW CAP REL COSTS-2007 MOB	00103		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	00201		2.01
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	ADMITTING	00510		5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	00560		5.02
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
7.01	OPERATION OF PLANT-SCC	00701		7.01
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
8.01	LAUNDRY & LINEN SERVICE-SCC	00801		8.01
9.00	HOUSEKEEPING	00900		9.00
9.01	HOUSEKEEPING-SCC	00901		9.01
10.00	DIETARY	01000		10.00
10.01	DIETARY-SCC	01001		10.01
11.00	CAFETERIA	01100		11.00
11.01	CAFETERIA-SCC	01101		11.01
13.00	NURSING ADMINISTRATION	01300		13.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
44.00	SKILLED NURSING FACILITY	04400		44.00
46.00	OTHER LONG TERM CARE	04600		46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	SLEEP LAB	03020		76.00
76.01	PAIN CLINIC	03021		76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	03530		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
93.00	FAMILY PRACTICE	04040		93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	MIDWEST MEDICAL CLINIC	19201		192.01

COST CENTERS USED IN COST REPORT

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet Non-CMS W

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
194.00 OTHER NONREIMBURSABLE	07950		194.00
194.01 ASSISTED LIVING UNITS	07951		194.01
194.02 ADULT DAY CARE	07952		194.02
194.03 GRANT FUNDED PROGRAMS	07953		194.03
194.04 IDLE SPACE	07954		194.04
194.05 COMMUNITY FITNESS CENTER	07955		194.05
200.00 TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE					
1.00	DIETARY-SCC	10.01	0	111,114	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	111,114	
C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	111,471	1.00
	TOTALS		0	111,471	
D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	12,738	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	38,374	2.00
	TOTALS		0	51,112	
E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	19,473	1.00
2.00	OTHER LONG TERM CARE	46.00	0	202,520	2.00
	TOTALS		0	221,993	
F - RECLASS PHARMACIST EXPENSE					
1.00	PHARMACY	15.00	0	108,000	1.00
	TOTALS		0	108,000	
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	8,484	848	1.00
	TOTALS		8,484	848	
H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,459,992	1.00
	TOTALS		0	1,459,992	
I - RECLASS NEW HOSPITAL BOND AMORTIZATN					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	27,327	1.00
	TOTALS		0	27,327	
J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	558,324	1.00
	TOTALS		0	558,324	
K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	2,646,809	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	399,760	2.00
	TOTALS		0	3,046,569	
L - RECLASS SENIOR CARE CAMPUS UTILITIES					
1.00	OPERATION OF PLANT-SCC	7.01	0	90,146	1.00
	TOTALS		0	90,146	
M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	10,209	1,531	1.00
	TOTALS		10,209	1,531	
P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	62,552	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	45,212	2.00
	TOTALS		0	107,764	
S - RECLASS CHIEF MED DIRECTOR FEES					
1.00		0.00	0	0	1.00
	TOTALS		0	0	
T - RECLASS RHC COSTS AFTER CERTIFICATN					
1.00		0.00	0	0	1.00
	TOTALS		0	0	
U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	8,348	1,493	1.00
2.00	OCCUPATIONAL THERAPY	67.00	7,939	1,420	2.00
	TOTALS		16,287	2,913	
V - RECLASS MEDICARE CERTIFIED SNF UNIT					
1.00	SKILLED NURSING FACILITY	44.00	6,738	1,663	1.00
	TOTALS		6,738	1,663	
X - RECLASS SURGEON FEES					
1.00	RURAL HEALTH CLINIC	88.00	0	77,960	1.00
2.00	OPERATING ROOM	50.00	0	6,040	2.00
	TOTALS		0	84,000	
Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	52,106	1.00
	TOTALS		0	52,106	

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
Z - RECLASS CMO CONTRACTED FEES FROM SAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	0	37,713	1.00
	TOTALS			0	37,713	
AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	ADULTS & PEDIATRICS		30.00	740	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	5,552	0	2.00
	TOTALS			6,292	0	
BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	SKILLED NURSING FACILITY		44.00	742	0	1.00
2.00	ASSISTED LIVING UNITS		194.01	7,682	0	2.00
3.00	ADULT DAY CARE		194.02	3,093	0	3.00
	TOTALS			11,517	0	
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE						
1.00			0.00	0	0	1.00
	TOTALS			0	0	
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	NURSING ADMINISTRATION		13.00	34,104	2,067	1.00
	TOTALS			34,104	2,067	
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC		8.01	0	39,783	1.00
	TOTALS			0	39,783	
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	9,050	1.00
2.00	SNF PHYSICAL THERAPY - SCC THERAPY		76.02	8,273	0	2.00
	TOTALS			8,273	9,050	
GG - RECLASS OUTSOURCE BILLING FEES						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	0	16,964	1.00
2.00			0.00	0	0	2.00
	TOTALS			0	16,964	
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	ADULTS & PEDIATRICS		30.00	58,682	7,043	1.00
	TOTALS			58,682	7,043	
II - RECLASS MEDICAL RECORD SALARIES						
1.00			0.00	0	0	1.00
	TOTALS			0	0	
JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	0	17,319	1.00
2.00	RADIOLOGY-DIAGNOSTIC		54.00	0	20,098	2.00
	TOTALS			0	37,417	
500.00	Grand Total: Increases			160,586	6,186,910	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS ADC AND ALU DIETARY EXPENSE							
1.00	ADULT DAY CARE	194.02	0	23,316	0		1.00
2.00	ASSISTED LIVING UNITS	194.01	0	87,798	0		2.00
	TOTALS		0	111,114			
C - RECLASS ASSISTED LIVING BUILDING DEP							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	111,471	9		1.00
	TOTALS		0	111,471			
D - RECLASS PT/MOB SPACE DEPRECIATION							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,738	9		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,374	9		2.00
	TOTALS		0	51,112			
E - RECLASS NURSING HOME ADMIN AND GEN							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	221,993	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	221,993			
F - RECLASS PHARMACIST EXPENSE							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	108,000	0		1.00
	TOTALS		0	108,000			
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT							
1.00	RURAL HEALTH CLINIC	88.00	8,484	848	0		1.00
	TOTALS		8,484	848			
H - RECLASS NEW HOSPITAL DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,459,992	9		1.00
	TOTALS		0	1,459,992			
I - RECLASS NEW HOSPITAL BOND AMORTIZATN							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	27,327	9		1.00
	TOTALS		0	27,327			
J - RECLASS NEW HOSPITAL MME DEPRECIATN							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	558,324	9		1.00
	TOTALS		0	558,324			
K - RECLASS INTEREST EXPENSE - NEW HOSP							
1.00	INTEREST EXPENSE	113.00	0	3,046,569	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	3,046,569			
L - RECLASS SENIOR CARE CAMPUS UTILITIES							
1.00	OPERATION OF PLANT	7.00	0	90,146	0		1.00
	TOTALS		0	90,146			
M - RECLASS PHYSICIAN IP ROUND TIME							
1.00	RURAL HEALTH CLINIC	88.00	10,209	1,531	0		1.00
	TOTALS		10,209	1,531			
P - RECLASS PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS	4.00	0	107,764	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	107,764			
S - RECLASS CHIEF MED DIRECTOR FEES							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
T - RECLASS RHC COSTS AFTER CERTIFICATN							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
U - RECLASS COMMUNITY FITNESS CTR USE							
1.00	PHYSICAL THERAPY	66.00	16,287	2,913	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		16,287	2,913			
V - RECLASS MEDICARE CERTIFIED SNF UNIT							
1.00	OTHER LONG TERM CARE	46.00	6,738	1,663	0		1.00
	TOTALS		6,738	1,663			
X - RECLASS SURGEON FEES							
1.00	RURAL HEALTH CLINIC	88.00	84,000	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		84,000	0			
Y - RECLASS PROPERTY INSURANCE EXP							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	52,106	12		1.00
	TOTALS		0	52,106			
Z - RECLASS CMO CONTRACTED FEES FROM SAL							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	37,713	0	0		1.00
	TOTALS		37,713	0			

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC	88.00	6,292	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		6,292	0			
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE	46.00	11,517	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		11,517	0			
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
DD - RECLASS NURSE PRACTITIONER MGMT TIME							
1.00	RURAL HEALTH CLINIC	88.00	34,104	2,067	0		1.00
	TOTALS		34,104	2,067			
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	39,783	0		1.00
	TOTALS		0	39,783			
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE	46.00	8,273	9,050	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		8,273	9,050			
GG - RECLASS OUTSOURCE BILLING FEES							
1.00	ASSISTED LIVING UNITS	194.01	0	8,482	0		1.00
2.00	ADULT DAY CARE	194.02	0	8,482	0		2.00
	TOTALS		0	16,964			
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC	88.00	58,682	7,043	0		1.00
	TOTALS		58,682	7,043			
II - RECLASS MEDICAL RECORD SALARIES							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
JJ - RECLASS CAP LEASE INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	37,417	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	37,417			
500.00	Grand Total: Decreases		282,299	6,065,197			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	DIETARY-SCC	10.01	0	ADULT DAY CARE	194.02	0 1.00
2.00		0.00	0	ASSISTED LIVING UNITS	194.01	0 2.00
	TOTALS		0	TOTALS		0
C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
	TOTALS		0	TOTALS		0
D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0 1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0 2.00
	TOTALS		0	TOTALS		0
E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	SKILLED NURSING FACILITY	44.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 1.00
2.00	OTHER LONG TERM CARE	46.00	0		0.00	0 2.00
	TOTALS		0	TOTALS		0
F - RECLASS PHARMACIST EXPENSE						
1.00	PHARMACY	15.00	0	DRUGS CHARGED TO PATIENTS	73.00	0 1.00
	TOTALS		0	TOTALS		0
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	ADULTS & PEDIATRICS	30.00	8,484	RURAL HEALTH CLINIC	88.00	8,484 1.00
	TOTALS		8,484	TOTALS		8,484
H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
	TOTALS		0	TOTALS		0
I - RECLASS NEW HOSPITAL BOND AMORTIZATN						
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
	TOTALS		0	TOTALS		0
J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0 1.00
	TOTALS		0	TOTALS		0
K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	INTEREST EXPENSE	113.00	0 1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0		0.00	0 2.00
	TOTALS		0	TOTALS		0
L - RECLASS SENIOR CARE CAMPUS UTILITIES						
1.00	OPERATION OF PLANT-SCC	7.01	0	OPERATION OF PLANT	7.00	0 1.00
	TOTALS		0	TOTALS		0
M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	ADULTS & PEDIATRICS	30.00	10,209	RURAL HEALTH CLINIC	88.00	10,209 1.00
	TOTALS		10,209	TOTALS		10,209
P - RECLASS PHYSICIAN BENEFITS						
1.00	RURAL HEALTH CLINIC	88.00	0	EMPLOYEE BENEFITS	4.00	0 1.00
2.00	RURAL HEALTH CLINIC	88.00	0		0.00	0 2.00
	TOTALS		0	TOTALS		0
S - RECLASS CHIEF MED DIRECTOR FEES						
1.00		0.00	0		0.00	0 1.00
	TOTALS		0	TOTALS		0
T - RECLASS RHC COSTS AFTER CERTIFICATN						
1.00		0.00	0		0.00	0 1.00
	TOTALS		0	TOTALS		0
U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	COMMUNITY FITNESS CENTER	194.05	8,348	PHYSICAL THERAPY	66.00	16,287 1.00
2.00	OCCUPATIONAL THERAPY	67.00	7,939		0.00	0 2.00
	TOTALS		16,287	TOTALS		16,287
V - RECLASS MEDICARE CERTIFIED SNF UNIT						
1.00	SKILLED NURSING FACILITY	44.00	6,738	OTHER LONG TERM CARE	46.00	6,738 1.00
	TOTALS		6,738	TOTALS		6,738
X - RECLASS SURGEON FEES						
1.00	RURAL HEALTH CLINIC	88.00	0	RURAL HEALTH CLINIC	88.00	84,000 1.00
2.00	OPERATING ROOM	50.00	0		0.00	0 2.00
	TOTALS		0	TOTALS		84,000
Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 1.00
	TOTALS		0	TOTALS		0

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
Z - RECLASS CMO CONTRACTED FEES FROM SAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	OTHER ADMINISTRATIVE AND GENERAL	5.02	37,713 1.00
	TOTALS		0	TOTALS		37,713
AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	ADULTS & PEDIATRICS	30.00	740	RURAL HEALTH CLINIC	88.00	6,292 1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	5,552		0.00	0 2.00
	TOTALS		6,292	TOTALS		6,292
BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	SKILLED NURSING FACILITY	44.00	742	OTHER LONG TERM CARE	46.00	11,517 1.00
2.00	ASSISTED LIVING UNITS	194.01	7,682		0.00	0 2.00
3.00	ADULT DAY CARE	194.02	3,093		0.00	0 3.00
	TOTALS		11,517	TOTALS		11,517
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE						
1.00		0.00	0		0.00	0 1.00
	TOTALS		0	TOTALS		0
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	NURSING ADMINISTRATION	13.00	34,104	RURAL HEALTH CLINIC	88.00	34,104 1.00
	TOTALS		34,104	TOTALS		34,104
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC	8.01	0	LAUNDRY & LINEN SERVICE	8.00	0 1.00
	TOTALS		0	TOTALS		0
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	OTHER LONG TERM CARE	46.00	8,273 1.00
2.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	8,273		0.00	0 2.00
	TOTALS		8,273	TOTALS		8,273
GG - RECLASS OUTSOURCE BILLING FEES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	ASSISTED LIVING UNITS	194.01	0 1.00
2.00		0.00	0	ADULT DAY CARE	194.02	0 2.00
	TOTALS		0	TOTALS		0
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	ADULTS & PEDIATRICS	30.00	58,682	RURAL HEALTH CLINIC	88.00	58,682 1.00
	TOTALS		58,682	TOTALS		58,682
II - RECLASS MEDICAL RECORD SALARIES						
1.00		0.00	0		0.00	0 1.00
	TOTALS		0	TOTALS		0
JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	INTEREST EXPENSE	113.00	0 1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0 2.00
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		160,586	Grand Total: Decreases		282,299 500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
2/24/2014 8:43 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	559,916	0	0	0	1.00
2.00	Land Improvements	3,713,316	0	0	0	2.00
3.00	Buildings and Fixtures	39,130,890	30,362	0	30,362	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	9,060,333	689,780	0	689,780	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,464,455	720,142	0	720,142	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,464,455	720,142	0	720,142	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	559,916	0			1.00
2.00	Land Improvements	3,713,316	0			2.00
3.00	Buildings and Fixtures	39,161,252	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	9,750,113	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	53,184,597	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	53,184,597	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		SUMMARY OF CAPITAL					
		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	1,668,420	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	612,632	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,281,052	0	0	0	0	3.00

Cost Center Description		SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,668,420	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	612,632	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	2.01
3.00	Total (sum of lines 1-2)	0	2,281,052	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	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	4,786,137	0	4,786,137	0.090949	4,739	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	2,673,151	0	2,673,151	0.050797	2,647	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,991,999	0	35,991,999	0.683937	35,637	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,273,839	0	3,273,839	0.062211	3,242	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	5,899,555	0	5,899,555	0.112106	5,841	2.01
3.00	Total (sum of lines 1-2)	52,624,681	0	52,624,681	1.000000	52,106	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	4,739	120,742	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,647	111,471	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	35,637	1,487,319	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	3,242	53,401	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	5,841	556,959	0	2.01
3.00	Total (sum of lines 1-2)	0	0	52,106	2,329,892	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,739	0	0	125,481	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,647	0	0	114,118	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	2,617,021	35,637	0	0	4,139,977	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,242	0	0	56,643	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	395,753	5,841	0	0	958,553	2.01
3.00	Total (sum of lines 1-2)	3,012,774	52,106	0	0	5,394,772	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #	wkst. A-7	Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
1.01 Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			0 NEW CAP REL COSTS-ALU BLDG	1.01		0 1.01
1.02 Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)			0 NEW CAP REL COSTS-2007 HOSPITAL	1.02		0 1.02
1.03 Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			0 NEW CAP REL COSTS-2007 MOB	1.03		0 1.03
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-271	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01		11 2.01
3.00 Investment income - other (chapter 2)	B	-1,798	NEW CAP REL COSTS-2007 HOSPITAL	1.02		11 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-5,824	OPERATION OF PLANT	7.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00 Television and radio service (chapter 21)		0		0.00		0 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-461,700				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests	B	-63,810	CAFETERIA	11.00		0 14.00
15.00 Rental of quarters to employee and others		0		0.00		0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts	B	-2,456	MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00 Vending machines		0		0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A	-41,148	INTEREST EXPENSE	113.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
26.01 Depreciation - NEW CAP REL COSTS-ALU BLDG			0 NEW CAP REL COSTS-ALU BLDG	1.01		0 26.01
26.02 Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0 NEW CAP REL COSTS-2007 HOSPITAL	1.02		0 26.02

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7	Ref.
			1.00	2.00	3.00	4.00
26.03 Depreciation - NEW CAP REL COSTS-2007 MOB			0 NEW CAP REL COSTS-2007 MOB	1.03		0 26.03
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01		0 27.01
28.00 Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0	0.00		0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0	0.00		0 32.00
33.00 OTHER ADJUSTMENTS (SPECIFY (3))			0	0.00		0 33.00
33.01 AR INSURANCE INTEREST INCOME	B	-6,231	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 33.01
33.05 DISALLOW PT BUYOUT AMORTIZATION EXP	A	-3,256	NEW CAP REL COSTS-2007 HOSPITAL	1.02		11 33.05
33.06 PART B BILLING COSTS	A	-18,312	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 33.06
33.07 PATIENT PHONE DEPRECIATION	A	-907	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9 33.07
33.08 PATIENT TELEVISION DEPRECIATION	A	-1,365	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01		9 33.08
33.09 MARKETING EXPENSES - NONALLOW	A	-39,804	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 33.09
34.00 LOBBYING EXPENSE ON DUES PAID	A	-9,091	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 34.00
35.00 COMMUNITY GRANTS / DONATIONS / PROM	A	-10,328	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 35.00
36.00 NH BED ASSESSMENT	A	-55,464	OTHER LONG TERM CARE	46.00		0 36.00
37.00 UNNECESSARY BORROWING ADJ - NEW HOSP	A	-24,734	NEW CAP REL COSTS-2007 HOSPITAL	1.02		11 37.00
38.00 UNNECESSARY BORROWING ADJ - NEW MME	A	-3,736	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01		11 38.00
40.00 SENIOR CARE CAMPUS CAFETERIA	B	-65,789	CAFETERIA-SCC	11.01		0 40.00
41.00 OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-96,575	DIETARY-SCC	10.01		0 41.00
42.00 RHC PROVIDER OR TIME	A	-10,775	RURAL HEALTH CLINIC	88.00		0 42.00
43.00 PENALTIES PAID (IRS/STATE)	A	-150	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 43.00
43.01 NH INTEREST FROM STATE OF ILLINOIS	B	-15,018	OTHER LONG TERM CARE	46.00		0 43.01
43.02 INTEREST INCOME	B	-12	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 43.02
43.03 INTEREST INCOME	B	-14	RADIOLOGY-DIAGNOSTIC	54.00		0 43.03
43.04 COLLECT AGENCY FEES NET IN PROV BDS	A	21,776	OTHER ADMINISTRATIVE AND GENERAL	5.02		0 43.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-916,792				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-2

Date/Time Prepared:
2/24/2014 8:44 am

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier		Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	91.00	EMERGENCY	1,034,368	178,428	855,940	0	0	1.00
2.00	60.00	LABORATORY	12,313	0	12,313	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	227,229	227,228	1	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	11,740	11,739	1	0	0	4.00
5.00	50.00	OPERATING ROOM	44,306	44,305	1	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,329,956	461,700	868,256			200.00
Wkst. A Line #	Cost Center/Physician Identifier		Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
Wkst. A Line #	Cost Center/Physician Identifier		Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
1.00	91.00	EMERGENCY	0	0	0	178,428		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	227,228		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	11,739		4.00
5.00	50.00	OPERATING ROOM	0	0	0	44,305		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	461,700		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2014 8:44 am
		Occupational Therapy	Cost

		1.00	
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PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	156	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	0.00	933.85	0.00	0.00	0.00	9.00
10.00	0.00	79.04	0.00	0.00	0.00	10.00
11.00	39.52	39.52	0.00			11.00
12.00	0	0	0			12.00
12.01	0	0	0			12.01
13.00	0	0	0			13.00
13.01	0	0	0			13.01

		1.00	
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Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	73,812	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	73,812	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	73,812	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	73,812	23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)	6,165	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	6,165	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	858	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	7,023	28.00
Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	8,721	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302		Period: From 10/01/2012 To 09/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2014 8:44 am	
		Occupational Therapy				Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.04	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					73,812	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					8,721	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					82,533	63.00
64.00	Total cost of outside supplier services (from your records)					51,362	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					6,165	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					858	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					7,023	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					858	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					858	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2014 8:44 am
		Speech Pathology	Cost

							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						9	1.00
2.00	Line 1 multiplied by 15 hours per week						135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						19	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.51	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	103.38	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.25	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.63	34.63	0.00				11.00
12.00	Number of travel hours (provider site)	0	9	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						7,159	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						7,159	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						7,159	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						69.25	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						9,349	22.00
23.00	Total salary equivalency (see instructions)						9,349	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						658	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						658	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						10	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						668	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						623	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						623	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						819	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY PROVIDER CCN: 141302
 OUTSIDE SUPPLIERS
 Period: From 10/01/2012 To 09/30/2013
 Worksheet A-8-3 Parts I-VI
 Date/Time Prepared: 2/24/2014 8:44 am

		Speech Pathology				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.25	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					9,349	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					819	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					10,168	63.00
64.00	Total cost of outside supplier services (from your records)					4,749	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					658	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					10	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					668	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					10	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					623	101.01
101.02	Line 34 = sum of lines 27 and 31					633	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					623	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					623	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	125,481	125,481			1.00
1.01 00101	NEW CAP REL COSTS-ALU BLDG	114,118	0	114,118		1.01
1.02 00102	NEW CAP REL COSTS-2007 HOSPITAL	4,139,977	0	0	4,139,977	1.02
1.03 00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	56,643				2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	958,553				2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,441,042	0	0	0	4.00
5.01 00510	ADMITTING	187,356	0	0	59,836	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	1,269,268	20,079	34,310	388,814	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	559,278	0	0	278,470	7.00
7.01 00701	OPERATION OF PLANT-SCC	269,206	4,781	0	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	53,917	0	0	28,139	8.00
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	39,783	478	0	0	8.01
9.00 00900	HOUSEKEEPING	103,450	0	0	21,342	9.00
9.01 00901	HOUSEKEEPING-SCC	69,113	909	0	0	9.01
10.00 01000	DIETARY	266,764	0	0	99,674	10.00
10.01 01001	DIETARY-SCC	438,184	3,534	0	0	10.01
11.00 01100	CAFETERIA	-63,810	0	0	153,739	11.00
11.01 01101	CAFETERIA-SCC	-65,789	0	0	0	11.01
13.00 01300	NURSING ADMINISTRATION	200,990	1,585	0	10,118	13.00
15.00 01500	PHARMACY	108,000	0	0	61,101	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	106,961	0	0	54,303	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	683,647	0	0	707,437	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
44.00 04400	SKILLED NURSING FACILITY	28,616	4,148	0	0	44.00
46.00 04600	OTHER LONG TERM CARE	1,371,536	43,150	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	249,594	0	0	425,570	50.00
53.00 05300	ANESTHESIOLOGY	70,800	0	0	4,268	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	712,520	0	0	287,007	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	615,910	0	0	85,051	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	27,605	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	21,831	0	0	14,860	65.00
66.00 06600	PHYSICAL THERAPY	653,535	0	0	369,528	66.00
67.00 06700	OCCUPATIONAL THERAPY	62,501	0	0	29,404	67.00
68.00 06800	SPEECH PATHOLOGY	4,749	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,199	0	0	53,908	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	217,694	0	0	0	73.00
76.00 03020	SLEEP LAB	0	0	0	0	76.00
76.01 03021	PAIN CLINIC	0	0	0	0	76.01
76.02 03530	SNF PHYSICAL THERAPY - SCC THERAPY	8,273	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,430,330	0	0	520,343	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,292,964	0	0	437,979	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,974,789	78,664	34,310	4,090,891	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,476	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
				1.00	1.01	1.02	1.03	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,278	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	248,149	0	73,833	0	0	194.01
194.02	07952	ADULT DAY CARE	112,260	0	5,975	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	46,817	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	9,841	0	0	25,610	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,372,317	125,481	114,118	4,139,977	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	Subtotal	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	56,643					2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	958,553				2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1,441,042			4.00
5.01 00510 ADMITTING	0	0	48,567	295,759		5.01
5.02 00560 OTHER ADMINISTRATIVE AND GENERAL	4,956	138,523	140,419	0	1,996,369	5.02
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	0	32,350	12,837	0	882,935	7.00
7.01 00701 OPERATION OF PLANT-SCC	6,974	0	18,132	0	299,093	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	790	0	0	82,846	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	40,261	8.01
9.00 00900 HOUSEKEEPING	0	4,790	27,396	0	156,978	9.00
9.01 00901 HOUSEKEEPING-SCC	0	0	18,351	0	88,373	9.01
10.00 01000 DIETARY	0	34,987	43,375	0	444,800	10.00
10.01 01001 DIETARY-SCC	2,210	0	53,343	0	497,271	10.01
11.00 01100 CAFETERIA	0	6,659	0	0	96,588	11.00
11.01 01101 CAFETERIA-SCC	0	0	0	0	-65,789	11.01
13.00 01300 NURSING ADMINISTRATION	329	153	39,913	0	253,088	13.00
15.00 01500 PHARMACY	0	4,600	0	0	173,701	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	422	263	27,064	0	189,013	16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	8,914	140,804	144,228	28,699	1,713,729	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	1,431	0	1,990	0	36,185	44.00
46.00 04600 OTHER LONG TERM CARE	14,886	0	290,827	0	1,720,399	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	140,322	29,681	22,256	867,423	50.00
53.00 05300 ANESTHESIOLOGY	0	32,433	0	4,945	112,446	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,230	344,600	70,761	75,771	1,497,889	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	180	7,285	63,861	58,033	830,320	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	13,984	41,589	64.00
65.00 06500 RESPIRATORY THERAPY	0	1,177	0	6,509	44,377	65.00
66.00 06600 PHYSICAL THERAPY	2,620	20,866	152,052	40,507	1,239,108	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	2,112	2,532	96,549	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	83	4,832	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	713	0	16,526	4,937	220,283	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	16,981	234,675	73.00
76.00 03020 SLEEP LAB	0	0	0	0	0	76.00
76.01 03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	2,201	0	10,474	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	170	33,192	87,043	0	2,071,078	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	3,599	13,207	63,819	20,522	1,832,090	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	54,634	957,001	1,354,498	295,759	17,708,973	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	220	0	0	23,696	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	27,278	192.00
192.01 19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01

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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	Subtotal	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01				
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	561	0	58,459	0	381,002	194.01
194.02	07952	ADULT DAY CARE	1,280	0	25,864	0	145,379	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	46,817	194.04
194.05	07955	COMMUNITY FITNESS CENTER	168	1,332	2,221	0	39,172	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	56,643	958,553	1,441,042	295,759	18,372,317	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
		5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMITTING					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,996,369				5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	128,099	0	1,011,034		7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	299,093	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	12,020	0	8,336	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	943	8.01
9.00	00900	HOUSEKEEPING	22,775	0	6,322	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	1,794	9.01
10.00	01000	DIETARY	64,533	0	29,528	0	10.00
10.01	01001	DIETARY-SCC	0	0	0	6,971	10.01
11.00	01100	CAFETERIA	14,013	0	45,544	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	36,719	0	2,997	3,126	13.00
15.00	01500	PHARMACY	25,201	0	18,101	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,423	0	16,087	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	248,633	0	209,572	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	8,181	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	85,107	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	125,848	0	126,072	0	50.00
53.00	05300	ANESTHESIOLOGY	16,314	0	1,264	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,318	0	85,024	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	120,465	0	25,196	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	6,034	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,438	0	4,402	0	65.00
66.00	06600	PHYSICAL THERAPY	179,774	0	109,470	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,008	0	8,711	0	67.00
68.00	06800	SPEECH PATHOLOGY	701	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,959	0	15,970	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,047	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	1,520	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	300,482	0	154,148	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	265,805	0	129,748	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	20,559	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,900,129	0	996,492	106,122	101,799
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,438	0	6,955	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,958	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	55,277	0	0	93,096	194.01

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	5.02	MAINTENANCE & REPAIRS	6.00	OPERATION OF PLANT	7.00	OPERATION OF PLANT-SCC	7.01	LAUNDRY & LINEN SERVICE	8.00
194.02	07952	ADULT DAY CARE	21,092	0	0	0	0	7,535	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	6,792	0	0	0	0	92,340	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	5,683	0	0	7,587	0	0	0	1,403	194.05
200.00		Cross Foot Adjustments									200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,996,369	0	0	1,011,034	0	299,093	0	103,202	202.00

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Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	41,204					8.01
9.00	00900 HOUSEKEEPING		191,296				9.00
9.01	00901 HOUSEKEEPING-SCC			90,167			9.01
10.00	01000 DIETARY		6,164		545,336		10.00
10.01	01001 DIETARY-SCC			3,081		507,323	10.01
11.00	01100 CAFETERIA		9,507		378,857		11.00
11.01	01101 CAFETERIA-SCC					14,689	11.01
13.00	01300 NURSING ADMINISTRATION		626	1,381			13.00
15.00	01500 PHARMACY		3,778				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		3,358				16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS						19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		43,744		166,479		30.00
41.00	04100 SUBPROVIDER - IRF						41.00
42.00	04200 SUBPROVIDER						42.00
44.00	04400 SKILLED NURSING FACILITY	248		3,616		2,133	44.00
46.00	04600 OTHER LONG TERM CARE	40,956		37,614		352,091	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		26,316				50.00
53.00	05300 ANESTHESIOLOGY		264				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		17,748				54.00
57.00	05700 CT SCAN						57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)						58.00
59.00	05900 CARDIAC CATHETERIZATION						59.00
60.00	06000 LABORATORY		5,259				60.00
60.01	06001 BLOOD LABORATORY						60.01
64.00	06400 INTRAVENOUS THERAPY						64.00
65.00	06500 RESPIRATORY THERAPY		919				65.00
66.00	06600 PHYSICAL THERAPY		8,329				66.00
67.00	06700 OCCUPATIONAL THERAPY		660				67.00
68.00	06800 SPEECH PATHOLOGY						68.00
69.00	06900 ELECTROCARDIOLOGY						69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,334				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300 DRUGS CHARGED TO PATIENTS						73.00
76.00	03020 SLEEP LAB						76.00
76.01	03021 PAIN CLINIC						76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY						76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		32,177				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLINIC						90.00
91.00	09100 EMERGENCY		27,084				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 FAMILY PRACTICE						93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF						99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION						109.00
110.00	11000 INTESTINAL ACQUISITION						110.00
111.00	11100 ISLET ACQUISITION						111.00
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,204	189,267	45,692	545,336	368,913	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,452				190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES						192.00
192.01	19201 MIDWEST MEDICAL CLINIC						192.01
194.00	07950 OTHER NONREIMBURSABLE						194.00
194.01	07951 ASSISTED LIVING UNITS			41,145		118,935	194.01

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Cost Center Description			LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	DIETARY	DIETARY-SCC	
			8.01	9.00	9.01	10.00	10.01	
194.02	07952	ADULT DAY CARE	0	0	3,330	0	19,475	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	577	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,204	191,296	90,167	545,336	507,323	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	11.01	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001						10.01
11.00	01100	544,509					11.00
11.01	01101	0	-51,100				11.01
13.00	01300	15,182	0	313,119			13.00
15.00	01500	0	0	0	220,781		15.00
16.00	01600	20,763	0	0	0	256,644	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	105,291	0	313,119	0	231,214	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	0	0	44.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,629	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	59,170	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	56,954	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	99,704	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	96,838	0	0	0	0	66.00
67.00	06700	5,991	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	13,459	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	121,077	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	106,685	0	0	0	17,684	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	39,146	0	0	0	7,746	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		538,108	0	313,119	220,781	256,644	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2012
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Cost Center Description			CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	11.01	13.00	15.00	16.00	
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	6,401	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	-51,100	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	544,509	-51,100	313,119	220,781	256,644	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	ADMITTING				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,067,126	0	3,067,126
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	50,363	0	50,363
46.00	04600	OTHER LONG TERM CARE	0	2,236,167	0	2,236,167
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,172,268	0	1,172,268
53.00	05300	ANESTHESIOLOGY	0	130,288	0	130,288
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,884,155	0	1,884,155
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	1,038,194	0	1,038,194
60.01	06001	BLOOD LABORATORY	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	147,327	0	147,327
65.00	06500	RESPIRATORY THERAPY	0	56,136	0	56,136
66.00	06600	PHYSICAL THERAPY	0	1,654,874	0	1,654,874
67.00	06700	OCCUPATIONAL THERAPY	0	127,236	0	127,236
68.00	06800	SPEECH PATHOLOGY	0	5,533	0	5,533
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	285,005	0	285,005
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	389,799	0	389,799
76.00	03020	SLEEP LAB	0	0	0	0
76.01	03021	PAIN CLINIC	0	0	0	0
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	11,994	0	11,994
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,684,959	0	2,684,959
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	2,322,178	0	2,322,178
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,263,602	0	17,263,602
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,541	0	35,541
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,236	0	31,236
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	689,455	0	689,455	194.01
194.02	07952	ADULT DAY CARE	0	196,811	0	196,811	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	145,949	0	145,949	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	60,823	0	60,823	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	-51,100	0	-51,100	201.00
202.00		TOTAL (sum lines 118-201)	0	18,372,317	0	18,372,317	202.00

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	99	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	30	SQUARE FEET	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	31	SQUARE FEET	1.02
1.03	NEW CAP REL COSTS-2007 MOB	73	SQUARE FEET	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	98	DOLLAR VALUE	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	97	DOLLAR VALUE	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
5.01	ADMITTING	49	GROSS CHARGES	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	-100	ACCUM. COST	5.02
6.00	MAINTENANCE & REPAIRS	75	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	8	SQUARE FT	7.00
7.01	OPERATION OF PLANT-SCC	79	SQUARE FT SCC	7.01
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
8.01	LAUNDRY & LINEN SERVICE-SCC	88	POUNDS OF LAUNDRY	8.01
9.00	HOUSEKEEPING	10	SQUARE FT	9.00
9.01	HOUSEKEEPING-SCC	71	SQUARE FT SCC	9.01
10.00	DIETARY	18	MEALS SERVED	10.00
10.01	DIETARY-SCC	78	MEALS SERVEDSCC	10.01
11.00	CAFETERIA	42	FTE	11.00
11.01	CAFETERIA-SCC	43	FTE'S -SCC	11.01
13.00	NURSING ADMINISTRATION	11	HOURS OF SERVICE	13.00
15.00	PHARMACY	16	GROSS CHARGES	15.00
16.00	MEDICAL RECORDS & LIBRARY	14	TIME SPENT	16.00
19.00	NONPHYSICIAN ANESTHETISTS	41	TIME SPENT	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2012
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Cost Center Description		CAPITAL RELATED COSTS					
		Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		NEW 2007 MOB
			0	1.00	1.01		1.02
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00510	ADMITTING	0	0	0	59,836	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	17,319	20,079	34,310	388,814	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	278,470	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	4,781	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	28,139	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	478	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	0	21,342	9.00
9.01	00901	HOUSEKEEPING-SCC	0	909	0	0	9.01
10.00	01000	DIETARY	0	0	0	99,674	10.00
10.01	01001	DIETARY-SCC	0	3,534	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	153,739	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	1,585	0	10,118	13.00
15.00	01500	PHARMACY	0	0	0	61,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	54,303	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	707,437	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	4,148	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	43,150	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	425,570	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,098	0	0	287,007	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	85,051	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,860	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	369,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	29,404	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	53,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,441	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	520,343	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	437,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,858	78,664	34,310	4,090,891	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,476	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB		
			0	1.00	1.01	1.02	1.03		
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	73,833	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	5,975	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	46,817	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	25,610	0	0	194.05
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers		0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	89,858	125,481	114,118	4,139,977			202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
		2.00	2.01				
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00510	ADMITTING	0	0	59,836	0	59,836
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	4,956	138,523	604,001	0	0
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	32,350	310,820	0	0
7.01	00701	OPERATION OF PLANT-SCC	6,974	0	11,755	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	790	28,929	0	0
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	478	0	0
9.00	00900	HOUSEKEEPING	0	4,790	26,132	0	0
9.01	00901	HOUSEKEEPING-SCC	0	0	909	0	0
10.00	01000	DIETARY	0	34,987	134,661	0	0
10.01	01001	DIETARY-SCC	2,210	0	5,744	0	0
11.00	01100	CAFETERIA	0	6,659	160,398	0	0
11.01	01101	CAFETERIA-SCC	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	329	153	12,185	0	0
15.00	01500	PHARMACY	0	4,600	65,701	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	422	263	54,988	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,914	140,804	857,155	0	5,807
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	1,431	0	5,579	0	0
46.00	04600	OTHER LONG TERM CARE	14,886	0	58,036	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	140,322	565,892	0	4,503
53.00	05300	ANESTHESIOLOGY	0	32,433	36,701	0	1,000
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,230	344,600	658,935	0	15,326
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	180	7,285	92,516	0	11,742
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,829
65.00	06500	RESPIRATORY THERAPY	0	1,177	16,037	0	1,317
66.00	06600	PHYSICAL THERAPY	2,620	20,866	393,014	0	8,196
67.00	06700	OCCUPATIONAL THERAPY	0	0	29,404	0	512
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	17
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	713	0	54,621	0	999
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	52,441	0	3,436
76.00	03020	SLEEP LAB	0	0	0	0	0
76.01	03021	PAIN CLINIC	0	0	0	0	0
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	170	33,192	553,705	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	3,599	13,207	454,785	0	4,152
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,634	957,001	5,305,358	0	59,836
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	220	23,696	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
194.00 07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07951 ASSISTED LIVING UNITS	561	0	74,394	0	0	194.01
194.02 07952 ADULT DAY CARE	1,280	0	7,255	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	0	46,817	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	168	1,332	27,110	0	0	194.05
200.00 Cross Foot Adjustments			0			200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	56,643	958,553	5,484,630	0	59,836	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
		5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMITTING					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	604,001				5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	38,756	0	349,576		7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	11,755	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,637	0	2,882	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	37	8.01
9.00	00900	HOUSEKEEPING	6,891	0	2,186	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	70	9.01
10.00	01000	DIETARY	19,524	0	10,209	0	10.00
10.01	01001	DIETARY-SCC	0	0	0	274	10.01
11.00	01100	CAFETERIA	4,240	0	15,747	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	11,109	0	1,036	123	13.00
15.00	01500	PHARMACY	7,625	0	6,258	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,297	0	5,562	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	75,224	0	72,464	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	322	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	3,345	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	38,076	0	43,591	0	50.00
53.00	05300	ANESTHESIOLOGY	4,936	0	437	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,750	0	29,398	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	36,447	0	8,712	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	1,826	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,948	0	1,522	0	65.00
66.00	06600	PHYSICAL THERAPY	54,391	0	37,850	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,238	0	3,012	0	67.00
68.00	06800	SPEECH PATHOLOGY	212	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,669	0	5,522	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,301	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	460	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	90,908	0	53,298	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	80,420	0	44,862	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,062	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	574,885	0	344,548	4,171	34,966
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,040	0	2,405	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,197	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	16,724	0	0	3,659	194.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.02	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	OPERATION OF PLANT-SCC 7.01	LAUNDRY & LINEN SERVICE 8.00	
194.02	07952 ADULT DAY CARE	6,381	0	0	296	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	2,055	0	0	3,629	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	1,719	0	2,623	0	482	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	604,001	0	349,576	11,755	35,448	202.00

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Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMITTING					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-SCC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	515				8.01
9.00	00900	HOUSEKEEPING	0	37,002			9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	979		9.01
10.00	01000	DIETARY	0	1,192	0	165,693	10.00
10.01	01001	DIETARY-SCC	0	0	33	0	10.01
11.00	01100	CAFETERIA	0	1,839	0	115,111	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	175	11.01
13.00	01300	NURSING ADMINISTRATION	0	121	15	0	13.00
15.00	01500	PHARMACY	0	731	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	650	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	8,460	0	50,582	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	3	0	39	0	44.00
46.00	04600	OTHER LONG TERM CARE	512	0	408	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,090	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	51	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,433	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	1,017	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,611	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	128	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	645	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,224	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	5,239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	515	36,609	495	165,693	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	281	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	448	1,419	194.01

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Cost Center Description		LAUNDRY & LINEN SERVICE-SCC 8.01	HOUSEKEEPING 9.00	HOUSEKEEPING-S CC 9.01	DIETARY 10.00	DIETARY-SCC 10.01	
194.02	07952 ADULT DAY CARE	0	0	36	0	232	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	112	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	515	37,002	979	165,693	6,051	202.00

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Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	11.01	13.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
1.01	00101						1.01	
1.02	00102						1.02	
1.03	00103						1.03	
2.00	00200						2.00	
2.01	00201						2.01	
4.00	00400						4.00	
5.01	00510						5.01	
5.02	00560						5.02	
6.00	00600						6.00	
7.00	00700						7.00	
7.01	00701						7.01	
8.00	00800						8.00	
8.01	00801						8.01	
9.00	00900						9.00	
9.01	00901						9.01	
10.00	01000						10.00	
10.01	01001						10.01	
11.00	01100	266,146					11.00	
11.01	01101	0	175				11.01	
13.00	01300	7,421	0	32,010			13.00	
15.00	01500	0	0	0	80,315		15.00	
16.00	01600	10,148	0	0	0	79,645	16.00	
19.00	01900	0	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	51,464	0	32,010	0	71,753	30.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
44.00	04400	0	0	0	0	0	44.00	
46.00	04600	0	0	0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	9,106	0	0	0	0	50.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	28,921	0	0	0	0	54.00	
57.00	05700	0	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	27,838	0	0	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
64.00	06400	0	0	0	36,270	0	64.00	
65.00	06500	0	0	0	0	0	65.00	
66.00	06600	47,333	0	0	0	0	66.00	
67.00	06700	2,928	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
69.00	06900	0	0	0	0	0	69.00	
71.00	07100	6,578	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	44,045	0	73.00	
76.00	03020	0	0	0	0	0	76.00	
76.01	03021	0	0	0	0	0	76.01	
76.02	03530	0	0	0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	52,146	0	0	0	5,488	88.00	
89.00	08900	0	0	0	0	0	89.00	
90.00	09000	0	0	0	0	0	90.00	
91.00	09100	19,134	0	0	0	2,404	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	04040	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	0	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	0	0	0	0	0	109.00	
110.00	11000	0	0	0	0	0	110.00	
111.00	11100	0	0	0	0	0	111.00	
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		263,017	0	32,010	80,315	79,645	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	11.01	13.00	15.00	16.00	
194.02	07952 ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	3,129	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	31,189	175	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	297,335	175	32,010	80,315	79,645	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	ADMITTING				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,237,059	0	1,237,059	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	5,968	0	5,968	44.00
46.00	04600	OTHER LONG TERM CARE	66,501	0	66,501	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	668,999	0	668,999	50.00
53.00	05300	ANESTHESIOLOGY	43,125	0	43,125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	804,170	0	804,170	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	178,272	0	178,272	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	40,925	0	40,925	64.00
65.00	06500	RESPIRATORY THERAPY	21,002	0	21,002	65.00
66.00	06600	PHYSICAL THERAPY	549,730	0	549,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,674	0	40,674	67.00
68.00	06800	SPEECH PATHOLOGY	229	0	229	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,034	0	78,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,223	0	110,223	73.00
76.00	03020	SLEEP LAB	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	460	0	460	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	762,698	0	762,698	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	618,058	0	618,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,226,127	5,226,127	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,422	0	27,422	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,197	0	1,197	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
194.00	07950	OTHER NONREIMBURSABLE		0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS		96,644	0	96,644	194.01
194.02	07952	ADULT DAY CARE		14,200	0	14,200	194.02
194.03	07953	GRANT FUNDED PROGRAMS		0	0	0	194.03
194.04	07954	IDLE SPACE		52,501	0	52,501	194.04
194.05	07955	COMMUNITY FITNESS CENTER		35,175	0	35,175	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	31,364	0	31,364	201.00
202.00		TOTAL (sum lines 118-201)	0	5,484,630	0	5,484,630	202.00

Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					53,398	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00510	ADMITTING	0	0	757	0	0	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	8,147	8,900	4,919	0	4,672	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	6,574	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	1,261	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	2,083	10.01
11.00	01100	CAFETERIA	0	0	1,945	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	310	13.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	398	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	8,950	0	8,403	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	1,349	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	14,034	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	6,816	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,076	0	170	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,675	0	2,470	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	682	0	672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	6,583	0	160	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	3,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,918	8,900	51,755	0	51,504	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	529	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	1,207	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	158	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	125,481	114,118	4,139,977	0	56,643	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	2.464568	3.855077	79.043398	0.000000	1.060770	203.00
204.00		Cost to be allocated (per wkst. B, Part II)						204.00
205.00		Unit cost multiplier (wkst. B, Part II)						205.00

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
	2.01	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02 00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03 00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	556,961				2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,415,906			4.00
5.01 00510	ADMITTING	0	182,529	13,762,317		5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	80,488	527,741	0	-1,996,369	13,760,155
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	18,797	48,244	0	0	882,935
7.01 00701	OPERATION OF PLANT-SCC	0	68,145	0	-299,093	0
8.00 00800	LAUNDRY & LINEN SERVICE	459	0	0	0	82,846
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	-40,261	0
9.00 00900	HOUSEKEEPING	2,783	102,962	0	0	156,978
9.01 00901	HOUSEKEEPING-SCC	0	68,969	0	-88,373	0
10.00 01000	DIETARY	20,329	163,017	0	0	444,800
10.01 01001	DIETARY-SCC	0	200,482	0	-497,271	0
11.00 01100	CAFETERIA	3,869	0	0	0	96,588
11.01 01101	CAFETERIA-SCC	0	0	0	65,789	0
13.00 01300	NURSING ADMINISTRATION	89	150,006	0	0	253,088
15.00 01500	PHARMACY	2,673	0	0	0	173,701
16.00 01600	MEDICAL RECORDS & LIBRARY	153	101,717	0	0	189,013
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	81,813	542,055	1,335,473	0	1,713,729
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	7,480	0	-36,185	0
46.00 04600	OTHER LONG TERM CARE	0	1,093,024	0	-1,720,399	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	81,533	111,550	1,035,641	0	867,423
53.00 05300	ANESTHESIOLOGY	18,845	0	230,086	0	112,446
54.00 05400	RADIOLOGY-DIAGNOSTIC	200,227	265,944	3,525,561	0	1,497,889
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	4,233	240,009	2,700,471	0	830,320
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	650,709	0	41,589
65.00 06500	RESPIRATORY THERAPY	684	0	302,870	0	44,377
66.00 06600	PHYSICAL THERAPY	12,124	571,461	1,884,928	0	1,239,108
67.00 06700	OCCUPATIONAL THERAPY	0	7,939	117,834	0	96,549
68.00 06800	SPEECH PATHOLOGY	0	0	3,874	0	4,832
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,110	229,728	0	220,283
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	790,198	0	234,675
76.00 03020	SLEEP LAB	0	0	0	0	0
76.01 03021	PAIN CLINIC	0	0	0	0	0
76.02 03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	8,273	0	0	10,474
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	19,286	327,134	0	0	2,071,078
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	7,674	239,854	954,944	0	1,832,090
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	556,059	5,090,645	13,762,317	-4,612,162	13,096,811
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	0	0	23,696

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)						
	2.01		4.00	5.01	5A.02	5.02	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		0	0	0	27,278	192.00
192.01 19201 MIDWEST MEDICAL CLINIC	0		0	0	0	0	192.01
194.00 07950 OTHER NONREIMBURSABLE	0		0	0	0	0	194.00
194.01 07951 ASSISTED LIVING UNITS	0		219,709	0	0	381,002	194.01
194.02 07952 ADULT DAY CARE	0		97,204	0	0	145,379	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0		0	0	0	0	194.03
194.04 07954 IDLE SPACE	0		0	0	0	46,817	194.04
194.05 07955 COMMUNITY FITNESS CENTER	774		8,348	0	0	39,172	194.05
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per wkst. B, Part I)	958,553		1,441,042	295,759		1,996,369	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	1.721042		0.266076	0.021490		0.145083	203.00
204.00 Cost to be allocated (per wkst. B, Part II)			0	59,836		604,001	204.00
205.00 Unit cost multiplier (wkst. B, Part II)			0.000000	0.004348		0.043895	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
		6.00	7.00	7.01	8.00	8.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700	0	43,177				7.00
7.01	00701	0	0	61,529			7.01
8.00	00800	0	356	0	143,866		8.00
8.01	00801	0	0	194	0	131,125	8.01
9.00	00900	0	270	0	7,278	0	9.00
9.01	00901	0	0	369	0	0	9.01
10.00	01000	0	1,261	0	434	0	10.00
10.01	01001	0	0	1,434	0	0	10.01
11.00	01100	0	1,945	0	0	0	11.00
11.01	01101	0	0	0	0	0	11.01
13.00	01300	0	128	643	0	0	13.00
15.00	01500	0	773	0	0	0	15.00
16.00	01600	0	687	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	8,950	0	49,269	0	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	1,683	0	789	44.00
46.00	04600	0	0	17,508	0	130,336	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,384	0	11,125	0	50.00
53.00	05300	0	54	0	0	0	53.00
54.00	05400	0	3,631	0	9,767	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,076	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	188	0	0	0	65.00
66.00	06600	0	4,675	0	29,770	0	66.00
67.00	06700	0	372	0	1,836	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	682	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	6,583	0	3,771	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	5,541	0	28,660	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		0	42,556	21,831	141,910	131,125	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	297	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
			6.00	7.00	7.01	8.00	8.01	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	19,152	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	1,550	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	18,996	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	324	0	1,956	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	0	1,011,034	299,093	103,202	41,204	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.000000	23.416032	4.861009	0.717348	0.314235	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	0	349,576	11,755	35,448	515	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000000	8.096348	0.191048	0.246396	0.003928	205.00

Cost Center Description		HOUSEKEEPING (SQURE FT)	HOUSEKEEPING-S CC (SQURE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
		9.00	9.01	10.00	10.01	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510 ADMITTING						5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC						8.00
9.00	00900 HOUSEKEEPING	39,137					9.00
9.01	00901 HOUSEKEEPING-SCC	0	41,970				9.01
10.00	01000 DIETARY	1,261	0	16,919			10.00
10.01	01001 DIETARY-SCC	0	1,434	0	78,021		10.01
11.00	01100 CAFETERIA	1,945	0	11,754	0	6,635	11.00
11.01	01101 CAFETERIA-SCC	0	0	0	2,259	0	11.01
13.00	01300 NURSING ADMINISTRATION	128	643	0	0	185	13.00
15.00	01500 PHARMACY	773	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	687	0	0	0	253	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,950	0	5,165	0	1,283	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	1,683	0	328	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	17,508	0	54,148	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,384	0	0	0	227	50.00
53.00	05300 ANESTHESIOLOGY	54	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,631	0	0	0	721	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	1,076	0	0	0	694	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	188	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,704	0	0	0	1,180	66.00
67.00	06700 OCCUPATIONAL THERAPY	135	0	0	0	73	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	682	0	0	0	164	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	6,583	0	0	0	1,300	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	5,541	0	0	0	477	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	38,722	21,268	16,919	56,735	6,557	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	297	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description			HOUSEKEEPING (SQURE FT)	HOUSEKEEPING-S CC (SQURE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
			9.00	9.01	10.00	10.01	11.00	
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	18,291	0	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	2,995	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	118	0	0	0	78	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	191,296	90,167	545,336	507,323	544,509	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	4.887855	2.148368	32.232165	6.502390	82.066164	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	37,002	979	165,693	6,051	297,335	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.945448	0.023326	9.793309	0.077556	40.112434	205.00

Cost Center Description		CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		11.01	13.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001						10.01
11.00	01100						11.00
11.01	01101						11.00
13.00	01300	4,722	2,080				11.01
15.00	01500	0	0	1,440,907			13.00
16.00	01600	0	0	0	5,268		15.00
19.00	01900	0	0	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	2,080	0	4,746		30.00
41.00	04100	0	0	0	0		41.00
42.00	04200	0	0	0	0		42.00
44.00	04400	310	0	0	0		44.00
46.00	04600	3,227	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	650,709	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	790,198	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
76.02	03530	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	363	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	159	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		3,537	2,080	1,440,907	5,268	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description			CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			11.01	13.00	15.00	16.00	19.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	887	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	298	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	-51,100	313,119	220,781	256,644	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	150.537981	0.153224	48.717540	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	175	32,010	80,315	79,645	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.037061	15.389423	0.055739	15.118641	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs
				Costs		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	3,067,126		3,067,126	0	3,067,126	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	50,363		50,363	0	50,363	44.00
46.00	04600	OTHER LONG TERM CARE	2,236,167		2,236,167	0	2,236,167	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,172,268		1,172,268	0	1,172,268	50.00
53.00	05300	ANESTHESIOLOGY	130,288		130,288	0	130,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,884,155		1,884,155	0	1,884,155	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,038,194		1,038,194	0	1,038,194	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	147,327		147,327	0	147,327	64.00
65.00	06500	RESPIRATORY THERAPY	56,136	0	56,136	0	56,136	65.00
66.00	06600	PHYSICAL THERAPY	1,654,874	0	1,654,874	0	1,654,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,236	0	127,236	0	127,236	67.00
68.00	06800	SPEECH PATHOLOGY	5,533	0	5,533	0	5,533	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	285,005		285,005	0	285,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,799		389,799	0	389,799	73.00
76.00	03020	SLEEP LAB	0		0	0	0	76.00
76.01	03021	PAIN CLINIC	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	11,994		11,994	0	11,994	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,684,959		2,684,959	0	2,684,959	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,322,178		2,322,178	0	2,322,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	261,630		261,630	0	261,630	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE	0		0		0	113.00
200.00		Subtotal (see instructions)	17,525,232	0	17,525,232	0	17,525,232	200.00
201.00		Less Observation Beds	261,630		261,630		261,630	201.00
202.00		Total (see instructions)	17,263,602	0	17,263,602	0	17,263,602	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description	Charges			Hospital	Cost	
	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	1,174,782		1,174,782	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	64,400		64,400	44.00
46.00	04600	OTHER LONG TERM CARE	3,790,743		3,790,743	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,837	978,804	1,035,641	50.00
53.00	05300	ANESTHESIOLOGY	30,000	200,086	230,086	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,653	3,413,908	3,525,561	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	242,447	2,458,024	2,700,471	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	115,812	534,897	650,709	64.00
65.00	06500	RESPIRATORY THERAPY	142,275	160,595	302,870	65.00
66.00	06600	PHYSICAL THERAPY	313,035	1,571,893	1,884,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	102,303	15,531	117,834	67.00
68.00	06800	SPEECH PATHOLOGY	1,794	2,080	3,874	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,130	132,598	229,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	482,602	307,596	790,198	73.00
76.00	03020	SLEEP LAB	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	22,960	0	22,960	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	39,077	2,118,629	2,157,706	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	70,713	884,231	954,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	160,691	160,691	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	6,858,563	12,939,563	19,798,126	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	6,858,563	12,939,563	19,798,126	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
44.00	04400 SKILLED NURSING FACILITY				44.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 SLEEP LAB	0.000000			76.00
76.01	03021 PAIN CLINIC	0.000000			76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/24/2014 8:43 am
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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	668,999	1,035,641	0.645976	24,098	15,567	50.00
53.00	05300 ANESTHESIOLOGY	43,125	230,086	0.187430	5,650	1,059	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	804,170	3,525,561	0.228097	54,112	12,343	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	178,272	2,700,471	0.066015	119,140	7,865	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	40,925	650,709	0.062893	15,484	974	64.00
65.00	06500 RESPIRATORY THERAPY	21,002	302,870	0.069343	80,653	5,593	65.00
66.00	06600 PHYSICAL THERAPY	549,730	1,884,928	0.291645	23,551	6,869	66.00
67.00	06700 OCCUPATIONAL THERAPY	40,674	117,834	0.345181	3,802	1,312	67.00
68.00	06800 SPEECH PATHOLOGY	229	3,874	0.059112	434	26	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78,034	229,728	0.339680	38,578	13,104	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	110,223	790,198	0.139488	113,807	15,875	73.00
76.00	03020 SLEEP LAB	0	0	0.000000	0	0	76.00
76.01	03021 PAIN CLINIC	0	0	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	460	22,960	0.020035	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	762,698	2,157,706	0.353476	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	618,058	954,944	0.647219	34,077	22,055	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	160,691	0.000000	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	3,916,599	14,768,201		513,386	102,642	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII			Hospital	Cost	Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03020	SLEEP LAB	0	0	0	0	0 76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0 76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0 93.00
200.00		Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,035,641	0.000000	0.000000	24,098	50.00
53.00	05300 ANESTHESIOLOGY	0	230,086	0.000000	0.000000	5,650	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,525,561	0.000000	0.000000	54,112	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	2,700,471	0.000000	0.000000	119,140	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	650,709	0.000000	0.000000	15,484	64.00
65.00	06500 RESPIRATORY THERAPY	0	302,870	0.000000	0.000000	80,653	65.00
66.00	06600 PHYSICAL THERAPY	0	1,884,928	0.000000	0.000000	23,551	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	117,834	0.000000	0.000000	3,802	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,874	0.000000	0.000000	434	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,728	0.000000	0.000000	38,578	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	790,198	0.000000	0.000000	113,807	73.00
76.00	03020 SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01	03021 PAIN CLINIC	0	0	0.000000	0.000000	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	22,960	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,157,706	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	954,944	0.000000	0.000000	34,077	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	160,691	0.000000	0.000000	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	14,768,201			513,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description	Title XVIII							
	Hospital							
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		Cost	
11.00	12.00	12.01	13.00	13.01				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description	Title XVIII				Cost
	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	21.00	22.00	23.00	24.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020 SLEEP LAB	0	0	0	0	76.00
76.01 03021 PAIN CLINIC	0	0	0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part V
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost	
			Title XVIII		Hospital			
			PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1.131925	0	0	380,833	0	50.00
53.00	05300	ANESTHESIOLOGY	0.566258	0	0	78,907	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.534427	0	0	1,182,694	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.384449	0	0	1,159,155	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.226410	0	0	44,528	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.185347	0	0	63,147	0	65.00
66.00	06600	PHYSICAL THERAPY	0.877951	0	0	767,969	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.079790	0	0	13,537	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.428240	0	0	1,856	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.240619	0	0	89,038	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493293	0	0	61,424	2,880	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.522387	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	2.431743	0	0	491,712	2,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628156	0	0	103,036	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	4,437,836	5,168	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	4,437,836	5,168	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part V
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII				Hospital	Cost
		Costs				Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
		PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)		
		5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	431,074	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	44,682	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	632,064	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	445,636	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	10,082	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,704	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	674,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	14,617	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,651	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	110,462	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	30,300	1,421	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	1,195,717	5,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	167,759	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
200.00		Subtotal (see instructions)	0	0	3,770,987	6,985	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	3,770,987	6,985	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/24/2014 8:44 am
		Component CCN: 142302	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	2.01	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1.131925	0	0	0	0 50.00
53.00	05300 ANESTHESIOLOGY	0.566258	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.534427	0	0	0	0 54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.384449	0	0	0	0 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00	06400 INTRAVENOUS THERAPY	0.226410	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.185347	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.877951	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	1.079790	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	1.428240	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.240619	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.493293	0	0	0	0 73.00
76.00	03020 SLEEP LAB	0.000000	0	0	0	0 76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	0	0 76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.522387	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	0.000000	0	0	0	0 90.00
91.00	09100 EMERGENCY	2.431743	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.628156	0	0	0	0 92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	0 93.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. services-Program Only Charges				0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period: From 10/01/2012

Worksheet D

Component CCN: 142302

To 09/30/2013

Part V

Date/Time Prepared: 2/24/2014 8:44 am

Cost Center Description		Title XVIII				Swing Beds - SNF	Cost
		Costs					
		PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	50.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
57.00	05700 CT SCAN	0	0	0	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000 LABORATORY	0	0	0	0	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01	
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00	03020 SLEEP LAB	0	0	0	0	76.00	
76.01	03021 PAIN CLINIC	0	0	0	0	76.01	
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000 CLINIC	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
93.00	04040 FAMILY PRACTICE	0	0	0	0	93.00	
200.00	Subtotal (see instructions)	0	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	0	202.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII				Skilled Nursing Facility		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period: From 10/01/2012

Worksheet D

Component CCN: 146140

To 09/30/2013

Part IV

Date/Time Prepared: 2/24/2014 8:44 am

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,035,641	0.000000	0.000000	0 50.00
53.00	05300	ANESTHESIOLOGY	0	230,086	0.000000	0.000000	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,525,561	0.000000	0.000000	0 54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00	06000	LABORATORY	0	2,700,471	0.000000	0.000000	2,301 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0	650,709	0.000000	0.000000	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	302,870	0.000000	0.000000	0 65.00
66.00	06600	PHYSICAL THERAPY	0	1,884,928	0.000000	0.000000	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	117,834	0.000000	0.000000	6,662 67.00
68.00	06800	SPEECH PATHOLOGY	0	3,874	0.000000	0.000000	369 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,728	0.000000	0.000000	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	790,198	0.000000	0.000000	18,545 73.00
76.00	03020	SLEEP LAB	0	0	0.000000	0.000000	0 76.00
76.01	03021	PAIN CLINIC	0	0	0.000000	0.000000	0 76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	22,960	0.000000	0.000000	22,786 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,157,706	0.000000	0.000000	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0 89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0 90.00
91.00	09100	EMERGENCY	0	954,944	0.000000	0.000000	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	160,691	0.000000	0.000000	0 92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0 93.00
200.00		Total (lines 50-199)	0	14,768,201			50,663 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII			Skilled Nursing Facility		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	PAIN CLINIC	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/24/2014 8:44 am

Component CCN: 146140

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		21.00	22.00	23.00	24.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.00	03020 SLEEP LAB	0	0	0	0		76.00
76.01	03021 PAIN CLINIC	0	0	0	0		76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000 CLINIC	0	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,790 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			553 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			415 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			708 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)			344 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			144 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)			41 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			332 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)			230 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)			797 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		130.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		135.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,067,126	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)		18,720	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		5,535	25.00
26.00	Total swing-bed cost (see instructions)		2,018,710	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,048,416	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,048,416	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)		1,895.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		629,429	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		629,429	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/24/2014 8:43 am

Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					335,923 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					965,352 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)					436,050 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,511,008 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,947,058 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					138 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,895.87 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					261,630 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/24/2014 8:43 am

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/24/2014 8:43 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description

1.00

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	112	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	112	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	112	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	112	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	50,363	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	50,363	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	50,363	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:

Worksheet D-1

Component CCN: 146140

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/24/2014 8:43 am

Title XVIII

Skilled Nursing

Facility

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					50,363	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					449.67	71.00
72.00 Program routine service cost (line 9 x line 71)					50,363	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					50,363	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					50,363	83.00
84.00 Program inpatient ancillary services (see instructions)					29,657	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					80,020	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1
Date/Time Prepared:
2/24/2014 8:43 am

Title XVIII

Skilled Nursing Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-3

Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)			
		1.00	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS					30.00
41.00	04100	SUBPROVIDER - IRF			351,248		41.00
42.00	04200	SUBPROVIDER			0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1.131925	24,098		27,277	50.00
53.00	05300	ANESTHESIOLOGY	0.566258	5,650		3,199	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.534427	54,112		28,919	54.00
57.00	05700	CT SCAN	0.000000	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0		0	59.00
60.00	06000	LABORATORY	0.384449	119,140		45,803	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0		0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.226410	15,484		3,506	64.00
65.00	06500	RESPIRATORY THERAPY	0.185347	80,653		14,949	65.00
66.00	06600	PHYSICAL THERAPY	0.877951	23,551		20,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.079790	3,802		4,105	67.00
68.00	06800	SPEECH PATHOLOGY	1.428240	434		620	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.240619	38,578		47,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.493293	113,807		56,140	73.00
76.00	03020	SLEEP LAB	0.000000	0		0	76.00
76.01	03021	PAIN CLINIC	0.000000	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.522387	0		0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			0	89.00
90.00	09000	CLINIC	0.000000	0		0	90.00
91.00	09100	EMERGENCY	2.431743	34,077		82,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.628156	0		0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0		0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		513,386		335,923	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)		513,386			202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302

Period: From 10/01/2012

Worksheet D-3

Component CCN: 142302

To 09/30/2013

Date/Time Prepared: 2/24/2014 8:44 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.131925	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.566258	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.534427	25,245	13,492	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.384449	85,051	32,698	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.226410	810	183	64.00
65.00	06500 RESPIRATORY THERAPY	0.185347	39,413	7,305	65.00
66.00	06600 PHYSICAL THERAPY	0.877951	241,706	212,206	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.079790	78,449	84,708	67.00
68.00	06800 SPEECH PATHOLOGY	1.428240	991	1,415	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.240619	25,791	31,997	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.493293	289,084	142,603	73.00
76.00	03020 SLEEP LAB	0.000000	0	0	76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.522387	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2.431743	15,840	38,519	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.628156	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		802,380	565,126	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)		802,380		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-3
Date/Time Prepared:
2/24/2014 8:44 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.131925	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.566258	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.534427	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.384449	2,301	885	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.226410	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.185347	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.877951	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.079790	6,662	7,194	67.00
68.00	06800 SPEECH PATHOLOGY	1.428240	369	527	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.240619	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.493293	18,545	9,148	73.00
76.00	03020 SLEEP LAB	0.000000	0	0	76.00
76.01	03021 PAIN CLINIC	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.522387	22,786	11,903	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	2.431743	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.628156	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		50,663	29,657	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)		50,663		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141302	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/24/2014 8:44 am
		Title XVIII	Hospital	Cost
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,777,972	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,777,972	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,815,752	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		9,963	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		651,195	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)		3,136,061	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)		3,136,061	30.00
31.00	Primary payer payments		13,614	31.00
32.00	Subtotal (line 30 minus line 31)		3,122,447	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)		6,653	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		5,855	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,653	36.00
37.00	Subtotal (see instructions)		3,128,302	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 (see instructions)		3,128,302	40.00
40.01	Sequestration adjustment (see instructions)		31,283	40.01
41.00	Interim payments		3,172,995	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-75,976	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
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)			0
				112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141302 Component CCN: 146140	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/24/2014 8:44 am
		Title XVIII	Skilled Nursing Facility	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	0		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200	0		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0		11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges	0		12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)	0		13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0		14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0		16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000		17.00
18.00	Total customary charges (see instructions)	0		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0		19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0		20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0		21.00
22.00	Interns and residents (see instructions)	0		22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0		23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0		24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)	0		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	0		27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)	0		28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)	0		29.00
30.00	Subtotal (sum of lines 27 through 29)	0		30.00
31.00	Primary payer payments	0		31.00
32.00	Subtotal (line 30 minus line 31)	0		32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	0		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		36.00
37.00	Subtotal (see instructions)	0		37.00
38.00	MSP-LCC reconciliation amount from PS&R	0		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	0		40.00
40.01	Sequestration adjustment (see instructions)	0		40.01
41.00	Interim payments	0		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	0		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141302 Component CCN: 146140	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/24/2014 8:44 am
	Title XVIII	Skilled Nursing Facility	PPS
	Overrides		
	1.00		
112.00	Override of Ancillary service charges (line 12)		0 112.00

WORKSHEET OVERRIDE VALUES

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2014 8:44 am

		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		699,690		3,365,006	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/12/2013	10,681	04/12/2013	192,011	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)		-10,681		-192,011	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)		689,009		3,172,995	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		182,215		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		75,976	6.02	
7.00	Total Medicare program liability (see instructions)		871,224		3,097,019	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302
Component CCN: 142302

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2014 8:44 am

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,178,437		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	09/23/2013	176,791		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	04/12/2013	25,783		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)		151,008		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,329,445		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		161,486		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,490,931		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302
Component CCN: 146140

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2014 8:44 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					
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		27,227		0	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		0		0	2.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		27,227		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		236		0	6.02
7.00	Total Medicare program liability (see instructions)		26,991		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141302
Component CCN: 142302

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-2
Date/Time Prepared:
2/24/2014 8:44 am

		Swing Beds - SNF		
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,966,529	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)	570,777	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,027	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,537,306	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,537,306	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,537,306	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	21,214	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,516,092	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,516,092	0	19.00
19.01	Sequestration adjustment (see instructions)	25,161	0	19.01
20.00	Interim payments	2,329,445	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	161,486	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-3
Part V
Date/Time Prepared:
2/24/2014 8:44 am

		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			965,352 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)			965,352 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			975,006 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)			975,006 19.00
20.00	Deductibles (exclude professional component)			106,000 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			869,006 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			869,006 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			12,521 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			11,018 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,521 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			880,024 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)			880,024 30.00
30.01	Sequestration adjustment (see instructions)			8,800 30.01
31.00	Interim payments			689,009 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			182,215 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302	Period: From 10/01/2012	Worksheet E-3
Component CCN: 146140	To 09/30/2013	Part VI
		Date/Time Prepared: 2/24/2014 8:44 am
Title XVIII	Skilled Nursing Facility	PPS

1.00

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	35,274 1.00
2.00	Routine service other pass through costs	0 2.00
3.00	Ancillary service other pass through costs	0 3.00
4.00	Subtotal (sum of lines 1 through 3)	35,274 4.00
COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of w/S E, Part B. This line is now shaded.)	5.00
6.00	Deductible	0 6.00
7.00	Coinsurance	8,010 7.00
8.00	Allowable bad debts (see instructions)	0 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0 9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0 10.00
11.00	Utilization review	0 11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	27,264 12.00
13.00	Inpatient primary payer payments	0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 14.00
14.99	Recovery of Accelerated Depreciation	0 14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)	27,264 15.00
15.01	Sequestration adjustment (see instructions)	273 15.01
16.00	Interim payments	27,227 16.00
17.00	Tentative settlement (for contractor use only)	0 17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	-236 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0 19.00

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

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet G
Date/Time Prepared:
2/24/2014 8:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,085,867	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,663,785	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,202,181	0	0	0	6.00
7.00	Inventory	329,055	0	0	0	7.00
8.00	Prepaid expenses	79,818	0	0	0	8.00
9.00	Other current assets	158,135	0	0	0	9.00
10.00	Due from other funds	1,893,061	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,007,540	0	0	0	11.00
FIXED ASSETS						
12.00	Land	559,916	0	0	0	12.00
13.00	Land improvements	3,713,316	0	0	0	13.00
14.00	Accumulated depreciation	-1,556,561	0	0	0	14.00
15.00	Buildings	39,161,252	0	0	0	15.00
16.00	Accumulated depreciation	-12,856,295	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,750,113	0	0	0	23.00
24.00	Accumulated depreciation	-7,285,810	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	1,644,510	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,130,441	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,057,761	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	800,607	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,858,368	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,996,349	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	706,154	0	0	0	37.00
38.00	Salaries, wages, and fees payable	545,044	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	786,668	0	0	0	40.00
41.00	Deferred income	94,085	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,523,061	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,655,012	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	46,303,973	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	46,303,973	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,958,985	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,962,636	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-3,962,636	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,996,349	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-1

Date/Time Prepared:
2/24/2014 8:44 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		-3,030,687		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-941,150			2.00
3.00	Total (sum of line 1 and line 2)		-3,971,837		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	RESTRICTED INVESTMENT INCOME	9,204		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)		9,204		0	10.00
11.00	Subtotal (line 3 plus line 10)		-3,962,633		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	ROUNDING	3		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)		3		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,962,636		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	RESTRICTED INVESTMENT INCOME		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ROUNDING		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2014 8:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,174,782		1,174,782	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	64,400		64,400	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,790,743		3,790,743	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,029,925		5,029,925	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,029,925		5,029,925	17.00
18.00	Ancillary services	1,678,639	0	1,678,639	18.00
19.00	Outpatient services	0	11,056,872	11,056,872	19.00
20.00	RURAL HEALTH CLINIC	0	2,118,629	2,118,629	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	1,816,965	1,816,965	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	6,708,564	14,992,466	21,701,030	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		19,289,109		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	504,661			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)		504,661		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		19,793,770		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141302

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-3

Date/Time Prepared:
2/24/2014 8:44 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	21,701,030	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,387,992	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,313,038	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	19,793,770	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,480,732	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	50,425	6.00
7.00	Income from investments	24,830	7.00
8.00	Revenues from telephone and other miscellaneous communication services	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	226,173	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,456	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	5,824	22.00
23.00	Governmental appropriations	15,865	23.00
24.00	GAIN ON SALE OF EQUIPMENT	1,697	24.00
24.01	ASSISTED LIVING UNITS	691,801	24.01
24.02	ADULT DAY CARE PROGRAM	243,910	24.02
24.03	FITNESS CENTER REVENUE	123,918	24.03
24.04	GRANT REVENUE	153,118	24.04
24.05	MASSAGE THERAPY REVENUE	0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	1,540,017	25.00
26.00	Total (line 5 plus line 25)	-940,715	26.00
27.00	EMPLOYEE LOAN FORGIVENESS	435	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	435	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-941,150	29.00

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

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2012
To 09/30/2013

Worksheet M-1
Date/Time Prepared:
2/24/2014 8:44 am

		Rural Health Clinic (RHC) I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	857,775	0	857,775	16,193	873,968	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	83,913	0	83,913	-36,289	47,624	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	167,135	0	167,135	0	167,135	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)	1,108,823	0	1,108,823	-20,096	1,088,727	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	88,075	88,075	0	88,075	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	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	88,075	88,075	0	88,075	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,108,823	88,075	1,196,898	-20,096	1,176,802	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	172,708	99,035	271,743	-7,403	264,340	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	172,708	99,035	271,743	-7,403	264,340	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,281,531	187,110	1,468,641	-27,499	1,441,142	32.00

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

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2012
To 09/30/2013

Worksheet M-1
Date/Time Prepared:
2/24/2014 8:44 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	Rural Health Clinic (RHC) I Cost
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-10,812	863,156	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	47,624	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	167,135	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)	-10,812	1,077,915	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	88,075	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	88,075	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-10,812	1,165,990	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	264,340	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	264,340	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,812	1,430,330	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141302
Component CCN: 148511

Period:
From 10/01/2012
To 09/30/2013

Worksheet M-2
Date/Time Prepared:
2/24/2014 8:44 am

				Rural Health Clinic (RHC) I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	

VISITS AND PRODUCTIVITY

Positions							
1.00	Physician	2.78	8,602	3,150	8,757		1.00
2.00	Physician Assistant	0.00	0	1,575	0		2.00
3.00	Nurse Practitioner	0.52	1,322	1,575	819		3.00
4.00	Subtotal (sum of lines 1-3)	3.30	9,924		9,576	9,924	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.30	9,924			9,924	8.00
9.00	Physician Services Under Agreements		0			0	9.00

1.00

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10.00	Total costs of health care services (from worksheet M-1, column 7, line 22)					1,165,990	10.00
11.00	Total nonreimbursable costs (from worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,165,990	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)					264,340	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,254,629	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,518,969	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,518,969	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,518,969	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,684,959	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141302	Period: From 10/01/2012	Worksheet M-3
		Component CCN: 148511	To 09/30/2013	Date/Time Prepared: 2/24/2014 8:44 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)			2,684,959 1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)			21,592 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,663,367 3.00
4.00	Total Visits (from worksheet M-2, column 5, line 8)			9,924 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)			9,924 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			268.38 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. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	268.38	268.38	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,636	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	707,450	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		707,450	16.00
16.01	Total program charges (see instructions)(from contractor's records)		559,202	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.)		532,554	16.04
16.05	Total program cost (see instructions)		532,554	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,758	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		103,488	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		532,554	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		10,422	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		542,976	22.00
23.00	Allowable bad debts (see instructions)		2,742	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		2,413	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		586	24.00
25.00	SEQUESTRATION		0	25.00
26.00	Net reimbursable amount (see instructions)		545,389	26.00
26.01	Sequestration adjustment (see instructions)		5,454	26.01
27.00	Interim payments		513,868	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		26,067	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4 Date/Time Prepared: 2/24/2014 8:44 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)	1,077,915	1,077,915	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000305	0.001234	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	329	1,330	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,220	3,498	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,549	4,828	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	1,165,990	1,165,990	6.00
7.00	Total overhead (from worksheet M-2, line 16)	1,518,969	1,518,969	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003901	0.004141	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,925	6,290	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	10,474	11,118	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	81	308	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	129.31	36.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	27	192	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,491	6,931	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to worksheet M-3, line 2)		21,592	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to worksheet M-3, line 21)		10,422	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2012 To 09/30/2013	worksheet M-5 Date/Time Prepared: 2/24/2014 8:44 am	
			Rural Health Clinic (RHC) I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			426,239	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			09/23/2013	134,942	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			04/12/2013	47,313	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)			87,629	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)			513,868	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			26,067	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			539,935	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00
8.00	Name of Contractor				8.00