

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/25/2014 4:23 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/25/2014 Time: 4:23 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASON DISTRICT HOSPITAL (141313) for the cost reporting period beginning 10/01/2012 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.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	98,615	48,551	93,952	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	104,317	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	89		0	9.00
10.00 RURAL HEALTH CLINIC I	0		91,194		0	10.00
10.01 RURAL HEALTH CLINIC II	0		1,397		0	10.01
200.00 Total	0	202,932	141,231	93,952	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: 141313		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/25/2014 3:25 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 615 NORTH PROMENADE STREET			PO Box:						1.00	
2.00	City: HAVANA			State: IL		Zip Code: 62644-0530		County: MASON		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
				V	XVIII	XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00	
21.00	Type of Control (see instructions)						11		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		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		25.00
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00

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		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)				0.00	0.00
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

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	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	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	3.00
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.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y			106.00

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		V	XIX			
		1.00	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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
		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	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	118,298	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00	

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1.00		2.00		3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00		
142.00	Street:	PO Box:				142.00		
143.00	City:	State:		Zip Code:		143.00		
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00	
						1.00		
						2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00	
		Part A		Part B		Title V	Title XIX	
		1.00		2.00		3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N		N		N	N 155.00	
156.00	Subprovider - IPF	N		N		N	N 156.00	
157.00	Subprovider - IRF	N		N		N	N 157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N		N		N	N 159.00	
160.00	HOME HEALTH AGENCY	N		N		N	N 160.00	
161.00	CMHC			N		N	N 161.00	
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N 165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00 166.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y 167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						97,260 168.00	
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)						10/01/2012	09/30/2013 170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/25/2014 3:25 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		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	01/11/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN		LI NHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404		DAN.LI NHART@MCGLADREY.COM	43.00

		Part B	
		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)	01/11/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	16,284.10	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	16,284.10	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	16,284.10	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	532	54	717			1.00
2.00 HMO and other (see instructions)	18	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	584	0	592			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	34			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,116	54	1,343			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,116	54	1,343	0.00	179.64	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	4,121	726	13,486	0.00	12.35	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
26.00 RURAL HEALTH CLINIC	5,168	3,505	14,129	0.00	32.15	26.00
26.01 RURAL HEALTH CLINIC II	296	793	1,773	0.00	4.07	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	228.21	27.00
28.00 Observation Bed Days		0	171			28.00
29.00 Ambulance Trips	626					29.00
30.00 Employee discount days (see instruction)			4			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

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	206	22	283	1.00
2.00 HMO and other (see instructions)			6			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	206	22	283	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141313 Component CCN: 147202		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/25/2014 3:25 pm		
				Home Health Agency I		PPS		
							1.00	
0.00	County	MASON					0.00	
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	702	40	348	1,090	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	170.00	10.00	84.00	264.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week		Staff	Contract	Total		
		0		1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00		0.51	0.00	0.51	3.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00	
5.00	Other Administrative Personnel			2.00	0.00	2.00	5.00	
6.00	Direct Nursing Service			9.30	0.00	9.30	6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00	
14.00	Medical Social Service			0.01	0.00	0.01	14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00	
16.00	Home Health Aide			0.52	0.00	0.52	16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00	
18.00	Other (specify)			0.00	0.00	0.00	18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914					20.00	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	3.00	4.00	5.00		
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	2,468	103	102	0	2,673	21.00	
22.00	Skilled Nursing Visit Charges	565,960	23,664	23,144	0	612,768	22.00	
23.00	Physical Therapy Visits	748	16	8	0	772	23.00	
24.00	Physical Therapy Visit Charges	192,265	4,120	2,060	0	198,445	24.00	
25.00	Occupational Therapy Visits	377	4	3	0	384	25.00	
26.00	Occupational Therapy Visit Charges	97,428	1,030	765	0	99,223	26.00	
27.00	Speech Pathology Visits	19	0	0	0	19	27.00	
28.00	Speech Pathology Visit Charges	4,893	0	0	0	4,893	28.00	
29.00	Medical Social Service Visits	7	0	0	0	7	29.00	
30.00	Medical Social Service Visit Charges	1,795	0	0	0	1,795	30.00	
31.00	Home Health Aide Visits	227	39	0	0	266	31.00	
32.00	Home Health Aide Visit Charges	29,228	5,021	0	0	34,249	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,846	162	113	0	4,121	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	891,569	33,835	25,969	0	951,373	35.00	
36.00	Total Number of Episodes (standard/non outlier)	201		41	0	242	36.00	
37.00	Total Number of Outlier Episodes		4		0	4	37.00	
38.00	Total Non-Routine Medical Supply Charges	6,589	328	619	0	7,536	38.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/25/2014 3:25 pm		
			Rural Health Clinic (RHC) I	Cost		
1.00						
Clinic Address and Identification						
1.00	Street	615 PROMENADE BOX 530		1.00		
		City	State	Zip Code		
		1.00	2.00	3.00		
2.00	City, State, Zip Code, County	HAVANA	IL	62644-0530		
1.00						
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award	Date		
			1.00	2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00	
7.00	Appalachian Regional Commission			0	7.00	
8.00	Look-Alikes			0	8.00	
9.00	OTHER (SPECIFY)			0	9.00	
1.00						
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1) Clinic			0800	1700	0800
1.00						
2.00						
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 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
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number			Total Visits		
		Y/N	V	XVIII	XIX	5.00
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			N	0	0
County						
4.00						
2.00	City, State, Zip Code, County			MASON		2.00
		Tuesday		Wednesday		Thursday
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
11.00	Facility hours of operations (1) Clinic			1700	0800	1700
11.00						

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/25/2014 3:25 pm
			Rural Health Clinic (RHC) I	Cost
		Friday		Saturday
		from	to	from
		11.00	12.00	13.00
				14.00
11.00	Facility hours of operations (1) Clinic	0800	1700	
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/25/2014 3:25 pm	
			Rural Health Clinic (RHC) II	Cost	
				1.00	
1.00	Clinic Address and Identification Street			615 N PROMENADE	1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		HAVANA	IL62644	2.00
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00
7.00	Appalachian Regional Commission			0	7.00
8.00	Look-Alikes			0	8.00
9.00	OTHER (SPECIFY)			0	9.00
				1.00	2.00
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0
		Sunday		Monday	Tuesday
		from	to	from	from
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) Clinic			0800	1700
				0800	11.00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 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
			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes 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
			County		
			4.00		
2.00	City, State, Zip Code, County			MASON	2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
11.00	Facility hours of operations (1) Clinic			1700	0800
				1700	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/25/2014 3:25 pm		
			Rural Health Clinic (RHC) II	Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	0800	1700			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/25/2014 3:25 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.626837	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		854,302	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,268,070	5.00	
6.00	Medicaid charges		2,641,111	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,655,546	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)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		15,718	9.00	
10.00	Stand-alone SCHIP charges		34,515	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		21,635	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		5,917	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		1,245,976	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,917	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	753,435	6,187	759,622	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	472,281	3,878	476,159	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	472,281	3,878	476,159	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			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)		1,766,079	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		428,797	27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		1,337,282	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		838,258	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,314,417	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,320,334	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141313

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

Worksheet A
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		323	323	303,673	303,996	1.00
1.01	00101		0	0	70,494	70,494	1.01
1.02	00102		0	0	585,699	585,699	1.02
2.00	00200		1,338,951	1,338,951	-551,690	787,261	2.00
4.00	00400	0	2,550,876	2,550,876	0	2,550,876	4.00
5.01	00510	988,734	1,408,208	2,396,942	0	2,396,942	5.01
5.02	00560	282,568	212,030	494,598	0	494,598	5.02
6.00	00600	259,498	164,047	423,545	0	423,545	6.00
7.00	00700	0	232,082	232,082	0	232,082	7.00
7.01	00701	0	20,765	20,765	0	20,765	7.01
8.00	00800	25,824	17,033	42,857	0	42,857	8.00
9.00	00900	228,242	71,573	299,815	0	299,815	9.00
10.00	01000	212,510	178,812	391,322	0	391,322	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	182,731	33,345	216,076	0	216,076	13.00
14.00	01400	73,345	5,035	78,380	0	78,380	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	135,322	52,693	188,015	0	188,015	16.00
19.00	01900	0	305,312	305,312	0	305,312	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	938,187	161,108	1,099,295	0	1,099,295	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	182,837	56,216	239,053	0	239,053	50.00
53.00	05300	0	434	434	0	434	53.00
54.00	05400	464,124	279,295	743,419	-98,372	645,047	54.00
54.01	05401	61,137	59,429	120,566	2,876	123,442	54.01
56.00	05600	39,019	71,926	110,945	801	111,746	56.00
58.00	05800	0	87,032	87,032	1,226	88,258	58.00
60.00	06000	603,241	484,502	1,087,743	73,253	1,160,996	60.00
62.00	06200	0	69,678	69,678	0	69,678	62.00
64.00	06400	0	7,064	7,064	0	7,064	64.00
66.00	06600	413,661	87,908	501,569	0	501,569	66.00
67.00	06700	145,066	37,640	182,706	0	182,706	67.00
68.00	06800	12,882	2,244	15,126	0	15,126	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	431,624	147,363	578,987	20,216	599,203	69.01
71.00	07100	0	278,630	278,630	0	278,630	71.00
73.00	07300	255,310	448,671	703,981	0	703,981	73.00
76.00	03020	272,458	175,069	447,527	0	447,527	76.00
76.01	03021	3,646	13,383	17,029	0	17,029	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	2,439,393	520,828	2,960,221	-88,532	2,871,689	88.00
88.01	08801	248,645	59,035	307,680	0	307,680	88.01
91.00	09100	359,379	1,379,260	1,738,639	546,766	2,285,405	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	779,869	94,608	874,477	-546,766	327,711	95.00
101.00	10100	499,214	105,244	604,458	0	604,458	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	408,176	408,176	-408,176	0	113.00
118.00		10,538,466	11,625,828	22,164,294	-88,532	22,075,762	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	18,381	1,783	20,164	88,532	108,696	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00		10,556,847	11,627,611	22,184,458	0	22,184,458	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141313

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

Worksheet A
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-14,046	289,950	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	70,494	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-25,634	560,065	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-134,817	652,444	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-689,230	1,861,646	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	-76,791	2,320,151	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-5,226	489,372	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	423,545	6.00
7.00	00700	OPERATION OF PLANT	-358	231,724	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,765	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,857	8.00
9.00	00900	HOUSEKEEPING	0	299,815	9.00
10.00	01000	DIETARY	-143,522	247,800	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-1,137	214,939	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,380	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,926	183,089	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	305,312	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,778	1,093,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	239,053	50.00
53.00	05300	ANESTHESIOLOGY	0	434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,659	615,388	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	123,442	54.01
56.00	05600	RADIOISOTOPE	0	111,746	56.00
58.00	05800	MRI	0	88,258	58.00
60.00	06000	LABORATORY	-1,151	1,159,845	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	69,678	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,064	64.00
66.00	06600	PHYSICAL THERAPY	0	501,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182,706	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,126	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	-54,725	544,478	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	278,630	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	703,981	73.00
76.00	03020	OP SENIOR HEALTH	-20	447,507	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	17,029	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-3,316	2,868,373	88.00
88.01	08801	RURAL HEALTH CLINIC II	-1,355	306,325	88.01
91.00	09100	EMERGENCY	-407,007	1,878,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-478	327,233	95.00
101.00	10100	HOME HEALTH AGENCY	-3,022	601,436	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,602,198	20,473,564	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-139	108,557	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,602,337	20,582,121	200.00

RECLASSIFICATIONS

Provider CCN: 141313

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

Worksheet A-6

Date/Time Prepared:
2/25/2014 3:25 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	117,243	1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	290,933	2.00
	TOTALS		0	408,176	
B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	546,766	0	1.00
	TOTALS		546,766	0	
C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	186,430	1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	70,494	2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	294,766	3.00
	TOTALS		0	551,690	
D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,532	0	1.00
	TOTALS		88,532	0	
E - OP REGISTRATION					
1.00	LABORATORY	60.00	67,415	5,838	1.00
2.00	CARDIOPULMONARY	69.01	18,605	1,611	2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,647	229	3.00
4.00	RADIOISOTOPE	56.00	737	64	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	5,166	447	5.00
6.00	MRI	58.00	1,128	98	6.00
	TOTALS		95,698	8,287	
500.00	Grand Total: Increases		730,996	968,153	500.00

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	408,176	11	1.00	
2.00		0.00	0	0	11	2.00	
	TOTALS		0	408,176			
B - EMS SALARY TO ER							
1.00	AMBULANCE SERVICES	95.00	546,766	0	0	1.00	
	TOTALS		546,766	0			
C - DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	551,690	9	1.00	
2.00		0.00	0	0	9	2.00	
3.00		0.00	0	0	9	3.00	
	TOTALS		0	551,690			
D - RHC PHYSICIAN							
1.00	RURAL HEALTH CLINIC	88.00	88,532	0	0	1.00	
	TOTALS		88,532	0			
E - OP REGISTRATION							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	95,698	8,287	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
	TOTALS		95,698	8,287			
500.00	Grand Total: Decreases		730,996	968,153		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	1.00
2.00	Land Improvements	559,643	23,000	0	23,000	2.00
3.00	Buildings and Fixtures	14,272,388	125,114	0	125,114	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	3,167,021	97,260	0	97,260	5.00
6.00	Movable Equipment	7,130,214	544,243	0	544,243	6.00
7.00	HIT designated Assets	689,559	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,982,753	789,617	0	789,617	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,982,753	789,617	0	789,617	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0			1.00
2.00	Land Improvements	582,643	0			2.00
3.00	Buildings and Fixtures	14,389,110	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	3,252,654	0			5.00
6.00	Movable Equipment	7,606,867	0			6.00
7.00	HIT designated Assets	689,559	0			7.00
8.00	Subtotal (sum of lines 1-7)	26,684,761	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	26,684,761	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Part II
Date/Time Prepared:
2/25/2014 3:25 pm

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	CAP REL COSTS-BLDG & FIXT	323	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,338,951	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,339,274	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	CAP REL COSTS-BLDG & FIXT	0	323				1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0				1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,338,951				2.00
3.00	Total (sum of lines 1-2)	0	1,339,274				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Part III
Date/Time Prepared:
2/25/2014 3:25 pm

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	CAP REL COSTS-BLDG & FIXT	18,446,962	0	18,446,962	0.689777	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	8,296,426	0	8,296,426	0.310223	0	2.00
3.00	Total (sum of lines 1-2)	26,743,388	0	26,743,388	1.000000	0	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	CAP REL COSTS-BLDG & FIXT	0	0	0	182,553	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	70,494	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	293,564	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	652,444	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,199,055	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	CAP REL COSTS-BLDG & FIXT	107,397	0	0	0	289,950	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	70,494	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	266,501	0	0	0	560,065	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	652,444	2.00
3.00	Total (sum of lines 1-2)	373,898	0	0	0	1,572,953	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00		0	1.00
1.01 Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			ONEW CAP REL COSTS-CLINIC BUILDING	1.01		0	1.01
1.02 Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			ONEW CAP REL COSTS-NEW MED SURG	1.02		0	1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0	0.00		0	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)			0	0.00		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	-471,718				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			0	0.00		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			0	0.00		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			0	0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00		0	26.00
26.01 Depreciation - NEW CAP REL COSTS-CLINIC BUILDING			ONEW CAP REL COSTS-CLINIC BUILDING	1.01		0	26.01
26.02 Depreciation - NEW CAP REL COSTS-NEW MED SURG			ONEW CAP REL COSTS-NEW MED SURG	1.02		0	26.02
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			ONONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
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	A	-149,326		CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00 MEDICAL RECORD FEES -OTHER OP	B	-4,926		MEDICAL RECORDS & LIBRARY	16.00	0 33.00
33.01 CAFETERIA SALES -OTHER OP	B	-143,522		DIETARY	10.00	0 33.01
33.02 SALE OF NON-PAT SUPP-OTHER OP	B	1,435		ADMINISTRATIVE & GENERAL	5.01	0 33.02
33.03 MISCELLANEOUS -OTHER OP	B	-181		ADMINISTRATIVE & GENERAL	5.01	0 33.03
33.04 RENTAL INCOME	B	-4,200		CAP REL COSTS-BLDG & FIXT	1.00	9 33.04
33.05 COMMUNITY ED FEES -OTHER OP	B	-1,155		ADMINISTRATIVE & GENERAL	5.01	0 33.05
33.06 LAB OUTREACH REV -OTHER OP	B	-113		LABORATORY	60.00	0 33.06
33.07		0			0.00	0 33.07
33.08 INTEREST INCOME -NON OPER	B	-9,846		CAP REL COSTS-BLDG & FIXT	1.00	11 33.08
33.09		0			0.00	0 33.09
33.10		0			0.00	0 33.10
33.11 INTEREST INCOME -NON OPER	B	-24,432		NEW CAP REL COSTS-NEW MED SURG	1.02	11 33.11
33.12 FITNESS REV OTHER	B	-16,423		CARDIOPULMONARY	69.01	0 33.12
33.13		0			0.00	0 33.13
33.14 EHR ASSET FY13 ADDITIONS DEPRE	A	14,509		CAP REL COSTS-MVBLE EQUIP	2.00	9 33.14
33.15		0			0.00	0 33.15
33.16		0			0.00	0 33.16
36.00 TELEPHONE OFFSET - OPERATIONS	A	-358		OPERATION OF PLANT	7.00	0 36.00
36.01 TELEPHONE OFFSET - SALARIES	A	-82		ADMINISTRATIVE & GENERAL	5.01	0 36.01
36.02 TELEPHONE OFFSET - BENEFITS	A	-15		EMPLOYEE BENEFITS	4.00	0 36.02
38.00 MEDI CAR - EXPENSES	A	-14,839		ADMINISTRATIVE & GENERAL	5.01	0 38.00
39.00 MEDI CAR - BENEFITS	A	-1,912		EMPLOYEE BENEFITS	4.00	0 39.00
40.00 LOBBYING DUES	A	-5,689		ADMINISTRATIVE & GENERAL	5.01	0 40.00
41.01 ADVERTISING	A	-56,280		ADMINISTRATIVE & GENERAL	5.01	0 41.01
42.00 ADVERTISING	A	-3,250		CARDIOPULMONARY	69.01	0 42.00
42.01 ADVERTISING	A	-3,022		HOME HEALTH AGENCY	101.00	0 42.01
43.00 ADVERTISING	A	-5,226		OTHER ADMINISTRATIVE AND GENERAL	5.02	0 43.00
43.01 ADVERTISING	A	-200		OP SENIOR HEALTH	76.00	0 43.01
43.02 ADVERTISING	A	-3,316		RURAL HEALTH CLINIC	88.00	0 43.02
43.03 ADVERTISING	A	-1,355		RURAL HEALTH CLINIC II	88.01	0 43.03
43.04 ADVERTISING	A	-478		AMBULANCE SERVICES	95.00	0 43.04
43.05 ADVERTISING	A	-5,778		ADULTS & PEDIATRICS	30.00	0 43.05
43.07 ADVERTISING	A	-1,038		LABORATORY	60.00	9 43.07
45.00 ADVERTISING	A	-1,137		NURSING ADMINISTRATIVE	13.00	0 45.00
45.01 ADVERTISING	A	-139		PHYSICIANS' PRIVATE OFFICES	192.00	0 45.01
45.02 TELEVISIONS	B	-1,202		NEW CAP REL COSTS-NEW MED SURG	1.02	9 45.02
45.03 SELF INSURANCE	B	-626,296		EMPLOYEE BENEFITS	4.00	0 45.03
45.05 UNFUNDED POST-EMPLOYMENT BENEFIT	A	-61,007		EMPLOYEE BENEFITS	4.00	0 45.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,602,337				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
2/25/2014 3:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,334,448	407,007	927,441	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	35,052	35,052	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	29,659	29,659	0	0	0	4.00
5.00	0.00		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			1,447,159	471,718	975,441	0	0	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	2.00	8.00	9.00	12.00	13.00	14.00	
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	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	0.00		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	2.00	15.00	16.00	17.00	18.00	
1.00	91.00	EMERGENCY	0	0	0	407,007	1.00
2.00	60.00	LABORATORY	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	35,052	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	29,659	4.00
5.00	0.00		0	0	0	0	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	471,718	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP		
		0	1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	289,950	289,950				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	70,494	0	70,494			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	560,065	0	0	560,065		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	652,444				652,444	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,861,646	0	0	0	0	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	2,320,151	58,329	3,740	77,447	12,415	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	489,372	2,864	4,606	4,597	6,276	5.02
6.00	00600	MAINTENANCE & REPAIRS	423,545	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	231,724	29,802	590	12,259	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	20,765	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	42,857	8,777	0	4,556	1,371	8.00
9.00	00900	HOUSEKEEPING	299,815	1,052	0	2,692	0	9.00
10.00	01000	DIETARY	247,800	14,268	0	0	1,075	10.00
11.00	01100	CAFETERIA	0	6,065	0	3,106	0	11.00
13.00	01300	NURSING ADMINISTRATION	214,939	5,913	0	6,668	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,380	7,629	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	183,089	7,202	717	0	134,391	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	305,312	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,093,517	4,343	0	436,605	11,316	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	239,053	35,119	0	0	46,331	50.00
53.00	05300	ANESTHESIOLOGY	434	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	615,388	26,438	0	0	252,009	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	123,442	1,367	0	0	0	54.01
56.00	05600	RADIOISOTOPE	111,746	2,971	0	0	1,833	56.00
58.00	05800	MRI	88,258	0	0	0	0	58.00
60.00	06000	LABORATORY	1,159,845	15,230	0	0	15,777	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	69,678	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	7,064	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	501,569	5,795	0	0	81,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	182,706	1,215	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,126	878	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	544,478	27,377	0	0	19,917	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	278,630	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,981	4,321	0	0	2,633	73.00
76.00	03020	OP SENIOR HEALTH	447,507	0	3,000	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	17,029	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,868,373	0	51,733	0	9,154	88.00
88.01	08801	RURAL HEALTH CLINIC II	306,325	0	0	0	977	88.01
91.00	09100	EMERGENCY	1,878,398	22,995	0	0	4,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	327,233	0	0	0	42,366	95.00
101.00	10100	HOME HEALTH AGENCY	601,436	0	6,108	0	8,137	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,473,564	289,950	70,494	547,930	651,830	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,135	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	108,557	0	0	0	614	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,582,121	289,950	70,494	560,065	652,444	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	4A	5.01	5A.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,861,646					4.00
5.01	00510	ADMINISTRATIVE & GENERAL	172,643	2,644,725	2,644,725			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	49,880	557,595	82,213	639,808	639,808	5.02
6.00	00600	MAINTENANCE & REPAIRS	45,808	469,353	69,202	538,555	23,365	6.00
7.00	00700	OPERATION OF PLANT	0	274,375	40,454	314,829	13,659	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,765	3,062	23,827	1,034	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	4,559	62,120	9,159	71,279	3,092	8.00
9.00	00900	HOUSEKEEPING	40,290	343,849	50,698	394,547	17,117	9.00
10.00	01000	DIETARY	37,513	300,656	44,329	344,985	14,967	10.00
11.00	01100	CAFETERIA	0	9,171	1,352	10,523	457	11.00
13.00	01300	NURSING ADMINISTRATION	32,256	259,776	38,302	298,078	12,932	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,947	98,956	14,590	113,546	4,926	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,888	349,287	51,500	400,787	17,388	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	305,312	45,016	350,328	15,199	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	165,613	1,711,394	252,331	1,963,725	85,194	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,275	352,778	52,014	404,792	17,561	50.00
53.00	05300	ANESTHESIOLOGY	0	434	64	498	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,948	959,783	141,512	1,101,295	47,779	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	11,259	136,068	20,062	156,130	6,774	54.01
56.00	05600	RADIOISOTOPE	7,018	123,568	18,219	141,787	6,151	56.00
58.00	05800	MRI	199	88,457	13,042	101,499	4,403	58.00
60.00	06000	LABORATORY	118,387	1,309,239	193,037	1,502,276	65,175	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	69,678	10,273	79,951	3,469	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,064	1,042	8,106	352	64.00
66.00	06600	PHYSICAL THERAPY	73,021	662,090	97,620	759,710	32,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,608	209,529	30,893	240,422	10,430	67.00
68.00	06800	SPEECH PATHOLOGY	2,274	18,278	2,695	20,973	910	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	79,476	671,248	98,970	770,218	33,415	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	278,630	41,082	319,712	13,870	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,068	756,003	111,467	867,470	37,634	73.00
76.00	03020	OP SENIOR HEALTH	48,095	498,602	73,515	572,117	24,821	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	644	17,673	2,606	20,279	880	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	414,985	3,344,245	493,083	3,837,328	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	43,892	351,194	51,781	402,975	0	88.01
91.00	09100	EMERGENCY	159,956	2,065,496	304,541	2,370,037	102,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	41,148	410,747	60,561	471,308	20,447	95.00
101.00	10100	HOME HEALTH AGENCY	88,123	703,804	103,770	807,574	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,842,773	20,441,942	2,624,057	20,421,274	639,204	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,135	1,789	13,924	604	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,873	128,044	18,879	146,923	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,861,646	20,582,121	2,644,725	20,582,121	639,808	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS	561,920					6.00
7.00	00700	OPERATION OF PLANT	47,378	375,866				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	24,861			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	13,759	13,340	0	101,470		8.00
9.00	00900	HOUSEKEEPING	2,086	2,022	0	0	415,772	9.00
10.00	01000	DIETARY	20,907	20,270	0	0	17,430	10.00
11.00	01100	CAFETERIA	9,505	9,216	0	0	7,925	11.00
13.00	01300	NURSING ADMINISTRATION	7,856	7,617	0	0	6,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,179	10,838	0	0	9,320	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,094	11,725	321	0	10,083	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,271	90,430	0	39,317	77,762	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	51,458	49,891	0	13,826	42,902	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,738	37,558	0	13,672	35,925	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,003	1,942	0	0	1,670	54.01
56.00	05600	RADIOISOTOPE	4,353	4,220	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	22,316	21,636	0	174	18,605	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,491	8,233	0	3,309	7,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,781	1,726	0	0	1,485	67.00
68.00	06800	SPEECH PATHOLOGY	1,286	1,247	0	0	1,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	40,115	38,893	0	2,509	33,444	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,331	6,138	0	0	5,279	73.00
76.00	03020	OP SENIOR HEALTH	6,455	6,258	1,345	0	5,382	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	111,309	0	23,195	1,122	92,799	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	48	0	88.01
91.00	09100	EMERGENCY	33,693	32,666	0	24,562	28,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	2,882	0	95.00
101.00	10100	HOME HEALTH AGENCY	13,141	0	0	49	10,956	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	559,505	375,866	24,861	101,470	413,758	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,415	0	0	0	2,014	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	561,920	375,866	24,861	101,470	415,772	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	418,559					10.00
11.00	01100	303,204	340,830				11.00
13.00	01300	0	3,742	336,775			13.00
14.00	01400	0	4,897	0	154,706		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	8,662	0	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	92,634	49,776	188,559	0	0	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,466	8,384	33,171	508	0	50.00
53.00	05300	0	0	0	74	0	53.00
54.00	05400	0	22,312	0	3,512	0	54.00
54.01	05401	0	2,564	0	37	0	54.01
56.00	05600	0	1,062	0	14,733	0	56.00
58.00	05800	0	115	0	595	0	58.00
60.00	06000	0	28,341	0	54,226	0	60.00
62.00	06200	0	0	0	15,991	0	62.00
64.00	06400	0	0	0	1,706	0	64.00
66.00	06600	0	15,452	0	0	0	66.00
67.00	06700	0	4,689	0	0	0	67.00
68.00	06800	0	254	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	0	28,272	0	4,786	0	69.01
71.00	07100	0	0	0	56,577	0	71.00
73.00	07300	0	8,800	0	0	0	73.00
76.00	03020	20,917	12,842	50,811	0	0	76.00
76.01	03021	0	208	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	73,682	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
91.00	09100	338	65,205	64,234	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	1,961	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		418,559	339,259	336,775	154,706	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,571	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		418,559	340,830	336,775	154,706	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,060					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		365,527				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,277	0	2,708,945	0	2,708,945	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,397	0	638,356	0	638,356	50.00
53.00	05300	ANESTHESIOLOGY	9,571	365,527	375,692	0	375,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,939	0	1,374,730	0	1,374,730	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	7,084	0	178,204	0	178,204	54.01
56.00	05600	RADIOISOTOPE	8,220	0	180,526	0	180,526	56.00
58.00	05800	MRI	11,197	0	117,809	0	117,809	58.00
60.00	06000	LABORATORY	89,425	0	1,802,174	0	1,802,174	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,491	0	100,902	0	100,902	62.00
64.00	06400	INTRAVENOUS THERAPY	5,348	0	15,512	0	15,512	64.00
66.00	06600	PHYSICAL THERAPY	19,611	0	854,844	0	854,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,727	0	268,260	0	268,260	67.00
68.00	06800	SPEECH PATHOLOGY	203	0	25,945	0	25,945	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	24,108	0	975,760	0	975,760	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,255	0	400,414	0	400,414	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,933	0	946,585	0	946,585	73.00
76.00	03020	OP SENIOR HEALTH	16,885	0	717,833	0	717,833	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	768	0	22,135	0	22,135	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	42,095	0	4,181,530	0	4,181,530	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,644	0	406,667	0	406,667	88.01
91.00	09100	EMERGENCY	32,394	0	2,754,041	0	2,754,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	22,020	0	518,618	0	518,618	95.00
101.00	10100	HOME HEALTH AGENCY	17,468	0	849,188	0	849,188	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	461,060	365,527	20,414,670	0	20,414,670	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,957	0	18,957	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	148,494	0	148,494	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	461,060	365,527	20,582,121	0	20,582,121	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		CAPITAL RELATED COSTS					
		Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG		MVBLE EQUIP
			0	1.00	1.01		1.02
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING				1.01	
1.02	00102	NEW CAP REL COSTS-NEW MED SURG				1.02	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	
5.01	00510	ADMINISTRATIVE & GENERAL	0	58,329	3,740	77,447	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	2,864	4,606	4,597	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	
7.00	00700	OPERATION OF PLANT	0	29,802	590	12,259	
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,777	0	4,556	
9.00	00900	HOUSEKEEPING	0	1,052	0	2,692	
10.00	01000	DIETARY	0	14,268	0	0	
11.00	01100	CAFETERIA	0	6,065	0	3,106	
13.00	01300	NURSING ADMINISTRATION	0	5,913	0	6,668	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,629	0	0	
15.00	01500	PHARMACY	0	0	0	0	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,202	717	0	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	134,391	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,343	0	436,605	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	11,316	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	35,119	0	0	
53.00	05300	ANESTHESIOLOGY	0	0	0	46,331	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,438	0	0	
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,367	0	252,009	
56.00	05600	RADIOISOTOPE	0	2,971	0	0	
58.00	05800	MRI	0	0	0	1,833	
60.00	06000	LABORATORY	0	15,230	0	0	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	15,777	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	
66.00	06600	PHYSICAL THERAPY	0	5,795	0	81,705	
67.00	06700	OCCUPATIONAL THERAPY	0	1,215	0	0	
68.00	06800	SPEECH PATHOLOGY	0	878	0	0	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	
69.01	03160	CARDIOPULMONARY	0	27,377	0	19,917	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,321	0	2,633	
76.00	03020	OP SENIOR HEALTH	0	0	3,000	0	
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	51,733	9,154	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	977	
91.00	09100	EMERGENCY	0	22,995	0	4,147	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	42,366	
101.00	10100	HOME HEALTH AGENCY	0	0	6,108	8,137	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	289,950	70,494	547,930	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,135	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	614	
194.00	07950	HOSPICE	0	0	0	0	
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	
194.02	07952	MEALS ON WHEELS	0	0	0	0	
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118-201)	0	289,950	70,494	560,065	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		2A	4.00	5.01	5.02	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.01	00510	ADMINISTRATIVE & GENERAL	151,931	0	151,931		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	18,343	0	4,723	23,066	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,975	842	4,817
7.00	00700	OPERATION OF PLANT	42,651	0	2,324	492	406
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	176	37	0
8.00	00800	LAUNDRY & LINEN SERVICE	14,704	0	526	111	118
9.00	00900	HOUSEKEEPING	3,744	0	2,912	617	18
10.00	01000	DIETARY	15,343	0	2,547	540	179
11.00	01100	CAFETERIA	9,171	0	78	16	81
13.00	01300	NURSING ADMINISTRATION	12,581	0	2,200	466	67
14.00	01400	CENTRAL SERVICES & SUPPLY	7,629	0	838	178	96
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	142,310	0	2,958	627	104
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,586	548	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	452,264	0	14,496	3,071	800
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	81,450	0	2,988	633	441
53.00	05300	ANESTHESIOLOGY	0	0	4	1	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,447	0	8,129	1,722	332
54.01	05401	RADIOLOGY-ULTRASOUND	1,367	0	1,152	244	17
56.00	05600	RADIOISOTOPE	4,804	0	1,047	222	37
58.00	05800	MRI	0	0	749	159	0
60.00	06000	LABORATORY	31,007	0	11,089	2,350	191
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	590	125	0
64.00	06400	INTRAVENOUS THERAPY	0	0	60	13	0
66.00	06600	PHYSICAL THERAPY	87,500	0	5,608	1,188	73
67.00	06700	OCCUPATIONAL THERAPY	1,215	0	1,775	376	15
68.00	06800	SPEECH PATHOLOGY	878	0	155	33	11
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03160	CARDIOPULMONARY	47,294	0	5,685	1,205	344
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,360	500	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,954	0	6,403	1,357	54
76.00	03020	OP SENIOR HEALTH	3,000	0	4,223	895	55
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	150	32	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	60,887	0	28,327	0	955
88.01	08801	RURAL HEALTH CLINIC II	977	0	2,975	0	0
91.00	09100	EMERGENCY	27,142	0	17,495	3,707	289
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	42,366	0	3,479	737	0
101.00	10100	HOME HEALTH AGENCY	14,245	0	5,961	0	113
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,560,204	0	150,743	23,044	4,796
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,135	0	103	22	21
192.00	19200	PHYSICIANS' PRIVATE OFFICES	614	0	1,085	0	0
194.00	07950	HOSPICE	0	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments	0				200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,572,953	0	151,931	23,066	4,817

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/25/2014 3:25 pm			
Cost Center Description		OPERATION OF PLANT 7.00	OPERATION OF PLANT-CLINIC 7.01	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	45,873				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	213			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,628	0	17,087		8.00
9.00	00900	HOUSEKEEPING	247	0	0	7,538	9.00
10.00	01000	DIETARY	2,474	0	0	316	10.00
11.00	01100	CAFETERIA	1,125	0	0	144	11.00
13.00	01300	NURSING ADMINISTRATION	930	0	0	119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,323	0	0	169	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,431	3	0	183	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,034	0	6,623	1,410	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,089	0	2,328	778	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,584	0	2,302	651	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	237	0	0	30	54.01
56.00	05600	RADIOISOTOPE	515	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,641	0	29	337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,005	0	557	128	66.00
67.00	06700	OCCUPATIONAL THERAPY	211	0	0	27	67.00
68.00	06800	SPEECH PATHOLOGY	152	0	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,747	0	422	606	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	749	0	0	96	73.00
76.00	03020	OP SENIOR HEALTH	764	12	0	98	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	198	189	1,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	8	0	88.01
91.00	09100	EMERGENCY	3,987	0	4,136	509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	485	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	8	199	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,873	213	17,087	7,501	21,399
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	37	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	45,873	213	17,087	7,538	21,399

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141313		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part II Date/Time Prepared: 2/25/2014 3:25 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	26,117					11.00
13.00	01300	287	16,650				13.00
14.00	01400	375	0	10,608			14.00
15.00	01500	0	0	0	0		15.00
16.00	01600	664	0	0	0	148,280	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,814	9,322	0	0	9,094	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	642	1,640	35	0	4,630	50.00
53.00	05300	0	0	5	0	3,078	53.00
54.00	05400	1,710	0	241	0	23,779	54.00
54.01	05401	196	0	3	0	2,278	54.01
56.00	05600	81	0	1,010	0	2,643	56.00
58.00	05800	9	0	41	0	3,601	58.00
60.00	06000	2,172	0	3,718	0	28,762	60.00
62.00	06200	0	0	1,096	0	480	62.00
64.00	06400	0	0	117	0	1,720	64.00
66.00	06600	1,184	0	0	0	6,307	66.00
67.00	06700	359	0	0	0	2,485	67.00
68.00	06800	19	0	0	0	65	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	2,166	0	328	0	7,753	69.01
71.00	07100	0	0	3,880	0	3,298	71.00
73.00	07300	674	0	0	0	4,802	73.00
76.00	03020	984	2,512	0	0	5,430	76.00
76.01	03021	16	0	0	0	247	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	5,649	0	0	0	13,538	88.00
88.01	08801	0	0	0	0	1,172	88.01
91.00	09100	4,996	3,176	0	0	10,418	91.00
92.00	09200						92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	134	0	7,082	95.00
101.00	10100	0	0	0	0	5,618	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		25,997	16,650	10,608	0	148,280	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	120	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		26,117	16,650	10,608	0	148,280	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/25/2014 3:25 pm
Cost Center	Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		19.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00510	ADMINISTRATIVE & GENERAL			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT-CLINIC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,134		19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	516,664	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	101,729	0	50.00
53.00	05300	ANESTHESIOLOGY	3,088	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,897	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,524	0	54.01
56.00	05600	RADIOISOTOPE	10,359	0	56.00
58.00	05800	MRI	4,559	0	58.00
60.00	06000	LABORATORY	82,296	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,291	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,910	0	64.00
66.00	06600	PHYSICAL THERAPY	103,550	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,463	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	70,550	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,038	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,089	0	73.00
76.00	03020	OP SENIOR HEALTH	19,042	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	445	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	111,425	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,132	0	88.01
91.00	09100	EMERGENCY	75,872	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	54,283	0	95.00
101.00	10100	HOME HEALTH AGENCY	26,144	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,555,682	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,318	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,819	0	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00		Cross Foot Adjustments	3,134	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,134	1,572,953	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	51,535				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				652,442	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	10,546,129	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	10,367	976	1,870	12,415	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	509	1,202	111	6,276	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,297	154	296	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	1,371	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	9.00
10.00	01000	DIETARY	2,536	0	0	1,075	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	0	161	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	134,391	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	772	0	10,542	11,316	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,242	0	0	46,331	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	0	252,007	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	1,833	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	0	15,777	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	81,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	19,917	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	2,633	73.00
76.00	03020	OP SENIOR HEALTH	0	783	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	9,154	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	977	88.01
91.00	09100	EMERGENCY	4,087	0	0	4,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	42,366	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	8,137	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,535	18,398	13,230	651,828	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	614	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	289,950	70,494	560,065	652,444	1,861,646
203.00		Unit cost multiplier (Wkst. B, Part I)	5.626273	3.831612	41.415736	1.000003	0.176524
204.00		Cost to be allocated (per Wkst. B, Part II)					0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
	BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
	1.00	1.01	1.02	2.00		
205.00 Unit cost multiplier (Wkst. B, Part II)					4.00 0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	-2,644,725	17,937,396				5.01
5.02	00560	0	557,595	-639,808	14,747,513		5.02
6.00	00600	0	469,353	0	538,555	68,162	6.00
7.00	00700	0	274,375	0	314,829	5,747	7.00
7.01	00701	0	20,765	0	23,827	0	7.01
8.00	00800	0	62,120	0	71,279	1,669	8.00
9.00	00900	0	343,849	0	394,547	253	9.00
10.00	01000	0	300,656	0	344,985	2,536	10.00
11.00	01100	0	9,171	0	10,523	1,153	11.00
13.00	01300	0	259,776	0	298,078	953	13.00
14.00	01400	0	98,956	0	113,546	1,356	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	349,287	0	400,787	1,467	16.00
19.00	01900	0	305,312	0	350,328	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,711,394	0	1,963,725	11,314	30.00
31.00	03100	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	352,778	0	404,792	6,242	50.00
53.00	05300	0	434	0	498	0	53.00
54.00	05400	0	959,783	0	1,101,295	4,699	54.00
54.01	05401	0	136,068	0	156,130	243	54.01
56.00	05600	0	123,568	0	141,787	528	56.00
58.00	05800	0	88,457	0	101,499	0	58.00
60.00	06000	0	1,309,239	0	1,502,276	2,707	60.00
62.00	06200	0	69,678	0	79,951	0	62.00
64.00	06400	0	7,064	0	8,106	0	64.00
66.00	06600	0	662,090	0	759,710	1,030	66.00
67.00	06700	0	209,529	0	240,422	216	67.00
68.00	06800	0	18,278	0	20,973	156	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	03160	0	671,248	0	770,218	4,866	69.01
71.00	07100	0	278,630	0	319,712	0	71.00
73.00	07300	0	756,003	0	867,470	768	73.00
76.00	03020	0	498,602	0	572,117	783	76.00
76.01	03021	0	17,673	0	20,279	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	3,344,245	-3,837,328	0	13,502	88.00
88.01	08801	0	351,194	-402,975	0	0	88.01
91.00	09100	0	2,065,496	0	2,370,037	4,087	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	410,747	0	471,308	0	95.00
101.00	10100	0	703,804	-807,574	0	1,594	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		-2,644,725	17,797,217	-5,687,685	14,733,589	67,869	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	12,135	0	13,924	293	190.00
192.00	19200	0	128,044	-146,923	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00			2,644,725		639,808	561,920	202.00
203.00			0.147442		0.043384	8.243890	203.00
204.00			151,931		23,066	4,817	204.00
205.00			0.008470		0.001564	0.070670	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		7.00	7.01	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01	
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	ADMINISTRATIVE & GENERAL					5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT	47,026				7.00	
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472			7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	59,498		8.00	
9.00	00900	HOUSEKEEPING	253	0	0	60,493	9.00	
10.00	01000	DIETARY	2,536	0	0	2,536	29,695	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	21,511	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	0	953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,467	187	0	1,467	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,314	0	23,054	11,314	6,572	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,242	0	8,107	6,242	104	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	8,017	5,227	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	102	2,707	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,940	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	1,471	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	768	0	73.00
76.00	03020	OP SENIOR HEALTH	783	783	0	783	1,484	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	13,502	658	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	28	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	14,402	4,087	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,690	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	29	1,594	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,026	14,472	59,498	60,200	29,695	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	375,866	24,861	101,470	415,772	418,559	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.992727	1.717869	1.705435	6.873060	14.095269	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,873	213	17,087	7,538	21,399	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.975482	0.014718	0.287186	0.124609	0.720626	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIRE)	PHARMACY (COSTED REQUIRE)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,756					11.00
13.00	01300	NURSING ADMINISTRATION	162	76,673				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	212	0	674,108			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375	0	0	0	32,567,733	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,155	42,929	0	0	1,997,392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	363	7,552	2,213	0	1,016,927	50.00
53.00	05300	ANESTHESIOLOGY	0	0	324	0	676,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	966	0	15,301	0	5,222,820	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	111	0	163	0	500,392	54.01
56.00	05600	RADIOISOTOPE	46	0	64,198	0	580,606	56.00
58.00	05800	MRI	5	0	2,592	0	790,883	58.00
60.00	06000	LABORATORY	1,227	0	236,282	0	6,316,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	69,678	0	105,340	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	7,434	0	377,781	64.00
66.00	06600	PHYSICAL THERAPY	669	0	0	0	1,385,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	203	0	0	0	545,779	67.00
68.00	06800	SPEECH PATHOLOGY	11	0	0	0	14,307	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,224	0	20,856	0	1,702,886	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	246,521	0	724,344	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	381	0	0	0	1,054,792	73.00
76.00	03020	OP SENIOR HEALTH	556	11,568	0	0	1,192,690	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	9	0	0	0	54,235	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,190	0	0	0	2,973,433	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	257,394	88.01
91.00	09100	EMERGENCY	2,823	14,624	0	0	2,288,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	8,546	0	1,555,437	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,233,901	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,688	76,673	674,108	0	32,567,733	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	68	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	340,830	336,775	154,706	0	461,060	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.097723	4.392355	0.229497	0.000000	0.014157	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,117	16,650	10,608	0	148,280	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.769924	0.217156	0.015736	0.000000	0.004553	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	OP SENIOR HEALTH	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	HOSPICE	194.00
194.01	07951	FAMILY MEDICAL CENTER	194.01
194.02	07952	MEALS ON WHEELS	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		365,527	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		3,655.270000	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		3,134	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		31.340000	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,708,945		2,708,945	0	2,708,945	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	638,356		638,356	0	638,356	50.00
53.00	05300 ANESTHESIOLOGY	375,692		375,692	0	375,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,374,730		1,374,730	0	1,374,730	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	178,204		178,204	0	178,204	54.01
56.00	05600 RADIOISOTOPE	180,526		180,526	0	180,526	56.00
58.00	05800 MRI	117,809		117,809	0	117,809	58.00
60.00	06000 LABORATORY	1,802,174		1,802,174	0	1,802,174	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	100,902		100,902	0	100,902	62.00
64.00	06400 INTRAVENOUS THERAPY	15,512		15,512	0	15,512	64.00
66.00	06600 PHYSICAL THERAPY	854,844	0	854,844	0	854,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	268,260	0	268,260	0	268,260	67.00
68.00	06800 SPEECH PATHOLOGY	25,945	0	25,945	0	25,945	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160 CARDIOPULMONARY	975,760		975,760	0	975,760	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	400,414		400,414	0	400,414	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	946,585		946,585	0	946,585	73.00
76.00	03020 OP SENIOR HEALTH	717,833		717,833	0	717,833	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	22,135		22,135	0	22,135	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	4,181,530		4,181,530	0	4,181,530	88.00
88.01	08801 RURAL HEALTH CLINIC II	406,667		406,667	0	406,667	88.01
91.00	09100 EMERGENCY	2,754,041		2,754,041	0	2,754,041	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	312,518		312,518		312,518	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	518,618		518,618	0	518,618	95.00
101.00	10100 HOME HEALTH AGENCY	849,188		849,188		849,188	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	20,727,188	0	20,727,188	0	20,727,188	200.00
201.00	Less Observation Beds	312,518		312,518		312,518	201.00
202.00	Total (see instructions)	20,414,670	0	20,414,670	0	20,414,670	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,620,217		1,620,217		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	101,652	915,275	1,016,927	0.627730	50.00
53.00	05300	ANESTHESIOLOGY	65,627	610,409	676,036	0.555728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	241,886	4,980,934	5,222,820	0.263216	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	34,549	465,843	500,392	0.356129	54.01
56.00	05600	RADIOISOTOPE	7,530	573,076	580,606	0.310927	56.00
58.00	05800	MRI	9,533	781,350	790,883	0.148959	58.00
60.00	06000	LABORATORY	592,662	5,724,235	6,316,897	0.285294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,552	60,788	105,340	0.957870	62.00
64.00	06400	INTRAVENOUS THERAPY	33,071	344,710	377,781	0.041061	64.00
66.00	06600	PHYSICAL THERAPY	226,626	1,158,628	1,385,254	0.617103	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,457	382,322	545,779	0.491518	67.00
68.00	06800	SPEECH PATHOLOGY	3,082	11,225	14,307	1.813448	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	281,487	1,421,399	1,702,886	0.573004	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	282,281	442,063	724,344	0.552795	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,335	715,457	1,054,792	0.897414	73.00
76.00	03020	OP SENIOR HEALTH	0	1,192,690	1,192,690	0.601861	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	54,235	54,235	0.408131	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,973,433	2,973,433		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	257,394	257,394		88.01
91.00	09100	EMERGENCY	8,575	2,279,632	2,288,207	1.203580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,925	375,250	377,175	0.828576	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,555,437	1,555,437	0.333423	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,233,901	1,233,901		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,058,047	28,509,686	32,567,733		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,058,047	28,509,686	32,567,733		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/25/2014 3:25 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160 CARDIOPULMONARY	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 OP SENIOR HEALTH	0.000000		76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,708,945		2,708,945	0	2,708,945	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	638,356		638,356	0	638,356	50.00
53.00	05300 ANESTHESIOLOGY	375,692		375,692	0	375,692	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,374,730		1,374,730	0	1,374,730	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	178,204		178,204	0	178,204	54.01
56.00	05600 RADIOISOTOPE	180,526		180,526	0	180,526	56.00
58.00	05800 MRI	117,809		117,809	0	117,809	58.00
60.00	06000 LABORATORY	1,802,174		1,802,174	0	1,802,174	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	100,902		100,902	0	100,902	62.00
64.00	06400 INTRAVENOUS THERAPY	15,512		15,512	0	15,512	64.00
66.00	06600 PHYSICAL THERAPY	854,844	0	854,844	0	854,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	268,260	0	268,260	0	268,260	67.00
68.00	06800 SPEECH PATHOLOGY	25,945	0	25,945	0	25,945	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160 CARDIOPULMONARY	975,760		975,760	0	975,760	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	400,414		400,414	0	400,414	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	946,585		946,585	0	946,585	73.00
76.00	03020 OP SENIOR HEALTH	717,833		717,833	0	717,833	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	22,135		22,135	0	22,135	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	4,181,530		4,181,530	0	4,181,530	88.00
88.01	08801 RURAL HEALTH CLINIC II	406,667		406,667	0	406,667	88.01
91.00	09100 EMERGENCY	2,754,041		2,754,041	0	2,754,041	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	312,518		312,518		312,518	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	518,618		518,618	0	518,618	95.00
101.00	10100 HOME HEALTH AGENCY	849,188		849,188		849,188	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	20,727,188	0	20,727,188	0	20,727,188	200.00
201.00	Less Observation Beds	312,518		312,518		312,518	201.00
202.00	Total (see instructions)	20,414,670	0	20,414,670	0	20,414,670	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,620,217		1,620,217		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	101,652	915,275	1,016,927	0.627730	50.00
53.00	05300	ANESTHESIOLOGY	65,627	610,409	676,036	0.555728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	241,886	4,980,934	5,222,820	0.263216	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	34,549	465,843	500,392	0.356129	54.01
56.00	05600	RADIOISOTOPE	7,530	573,076	580,606	0.310927	56.00
58.00	05800	MRI	9,533	781,350	790,883	0.148959	58.00
60.00	06000	LABORATORY	592,662	5,724,235	6,316,897	0.285294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,552	60,788	105,340	0.957870	62.00
64.00	06400	INTRAVENOUS THERAPY	33,071	344,710	377,781	0.041061	64.00
66.00	06600	PHYSICAL THERAPY	226,626	1,158,628	1,385,254	0.617103	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,457	382,322	545,779	0.491518	67.00
68.00	06800	SPEECH PATHOLOGY	3,082	11,225	14,307	1.813448	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	281,487	1,421,399	1,702,886	0.573004	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	282,281	442,063	724,344	0.552795	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,335	715,457	1,054,792	0.897414	73.00
76.00	03020	OP SENIOR HEALTH	0	1,192,690	1,192,690	0.601861	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	54,235	54,235	0.408131	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,973,433	2,973,433	1.406297	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	257,394	257,394	1.579940	88.01
91.00	09100	EMERGENCY	8,575	2,279,632	2,288,207	1.203580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,925	375,250	377,175	0.828576	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,555,437	1,555,437	0.333423	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,233,901	1,233,901		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,058,047	28,509,686	32,567,733		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,058,047	28,509,686	32,567,733		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/25/2014 3:25 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160 CARDIOPULMONARY	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 OP SENIOR HEALTH	0.000000		76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/25/2014 3:25 pm
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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	101,729	1,016,927	0.100036	72,737	7,276	50.00
53.00	05300 ANESTHESIOLOGY	3,088	676,036	0.004568	48,212	220	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	321,897	5,222,820	0.061633	157,113	9,683	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	5,524	500,392	0.011039	21,993	243	54.01
56.00	05600 RADIOISOTOPE	10,359	580,606	0.017842	5,852	104	56.00
58.00	05800 MRI	4,559	790,883	0.005764	6,411	37	58.00
60.00	06000 LABORATORY	82,296	6,316,897	0.013028	342,895	4,467	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,291	105,340	0.021749	37,321	812	62.00
64.00	06400 INTRAVENOUS THERAPY	1,910	377,781	0.005056	14,244	72	64.00
66.00	06600 PHYSICAL THERAPY	103,550	1,385,254	0.074752	60,301	4,508	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,463	545,779	0.011842	37,964	450	67.00
68.00	06800 SPEECH PATHOLOGY	1,332	14,307	0.093101	836	78	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	70,550	1,702,886	0.041430	161,099	6,674	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,038	724,344	0.013858	177,700	2,463	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,089	1,054,792	0.019994	123,926	2,478	73.00
76.00	03020 OP SENIOR HEALTH	19,042	1,192,690	0.015966	0	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	445	54,235	0.008205	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	111,425	2,973,433	0.037474	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	5,132	257,394	0.019938	0	0	88.01
91.00	09100 EMERGENCY	75,872	2,288,207	0.033158	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	377,175	0.000000	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	958,591	28,158,178		1,268,604	39,565	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	365,527	0	0	0	365,527	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00	
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
200.00		Total (lines 50-199)	365,527	0	0	0	365,527	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/25/2014 3:25 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,016,927	0.000000	0.000000	72,737	50.00
53.00	05300 ANESTHESIOLOGY	0	676,036	0.540692	0.000000	48,212	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,222,820	0.000000	0.000000	157,113	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0	500,392	0.000000	0.000000	21,993	54.01
56.00	05600 RADIOISOTOPE	0	580,606	0.000000	0.000000	5,852	56.00
58.00	05800 MRI	0	790,883	0.000000	0.000000	6,411	58.00
60.00	06000 LABORATORY	0	6,316,897	0.000000	0.000000	342,895	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	105,340	0.000000	0.000000	37,321	62.00
64.00	06400 INTRAVENOUS THERAPY	0	377,781	0.000000	0.000000	14,244	64.00
66.00	06600 PHYSICAL THERAPY	0	1,385,254	0.000000	0.000000	60,301	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	545,779	0.000000	0.000000	37,964	67.00
68.00	06800 SPEECH PATHOLOGY	0	14,307	0.000000	0.000000	836	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160 CARDIOPULMONARY	0	1,702,886	0.000000	0.000000	161,099	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	724,344	0.000000	0.000000	177,700	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,054,792	0.000000	0.000000	123,926	73.00
76.00	03020 OP SENIOR HEALTH	0	1,192,690	0.000000	0.000000	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0	54,235	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,973,433	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	257,394	0.000000	0.000000	0	88.01
91.00	09100 EMERGENCY	0	2,288,207	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	377,175	0.000000	0.000000	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	28,158,178			1,268,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description			Title XVIII			Hospital		Cost
			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	0	50.00
53.00	05300	ANESTHESIOLOGY	26,068	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	26,068	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/25/2014 3:25 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	0.627730	0	0	456,094	0	50.00	
53.00 05300 ANESTHESIOLOGY	0.555728	0	0	317,528	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.263216	0	0	2,266,543	0	54.00	
54.01 05401 RADIOLOGY-ULTRASOUND	0.356129	0	0	208,551	0	54.01	
56.00 05600 RADIOISOTOPE	0.310927	0	0	312,100	0	56.00	
58.00 05800 MRI	0.148959	0	0	314,336	0	58.00	
60.00 06000 LABORATORY	0.285294	0	0	3,068,015	0	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.957870	0	0	55,639	0	62.00	
64.00 06400 INTRAVENOUS THERAPY	0.041061	0	0	149,926	0	64.00	
66.00 06600 PHYSICAL THERAPY	0.617103	0	0	511,725	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.491518	0	0	112,638	0	67.00	
68.00 06800 SPEECH PATHOLOGY	1.813448	0	0	6,490	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
69.01 03160 CARDIOPULMONARY	0.573004	0	0	761,970	0	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.552795	0	0	208,065	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.897414	0	0	438,872	497	73.00	
76.00 03020 OP SENIOR HEALTH	0.601861	0	0	1,191,718	0	76.00	
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.408131	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00	
88.01 08801 RURAL HEALTH CLINIC II	0.000000					88.01	
91.00 09100 EMERGENCY	1.203580	0	0	733,994	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.828576	0	0	75,313	0	92.00	
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0.333423			0		95.00	
200.00	Subtotal (see instructions)		0	11,189,517	497	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	11,189,517	497	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/25/2014 3:25 pm
	Title XVIII	Hospital	Cost

Cost Center Description	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	286,304	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0	176,459	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	596,590	0		54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0	0	74,271	0		54.01
56.00 05600 RADIOISOTOPE	0	0	97,040	0		56.00
58.00 05800 MRI	0	0	46,823	0		58.00
60.00 06000 LABORATORY	0	0	875,286	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	53,295	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	6,156	0		64.00
66.00 06600 PHYSICAL THERAPY	0	0	315,787	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	55,364	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	11,769	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01 03160 CARDIOPULMONARY	0	0	436,612	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	115,017	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	393,850	446		73.00
76.00 03020 OP SENIOR HEALTH	0	0	717,249	0		76.00
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0		88.01
91.00 09100 EMERGENCY	0	0	883,420	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	62,403	0		92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES			0			95.00
200.00 Subtotal (see instructions)	0	0	5,203,695	446		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	5,203,695	446		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141313

Period:

Worksheet D

Component CCN: 14Z313

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

Part V
Date/Time Prepared:
2/25/2014 3:25 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		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	0.627730	0	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.555728	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.263216	0	0	0	0	0	54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0.356129	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0.310927	0	0	0	0	0	56.00
58.00 05800 MRI	0.148959	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0.285294	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.957870	0	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.041061	0	0	0	0	0	64.00
66.00 06600 PHYSICAL THERAPY	0.617103	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.491518	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.813448	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01 03160 CARDIOPULMONARY	0.573004	0	0	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.552795	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.897414	0	0	0	0	0	73.00
76.00 03020 OP SENIOR HEALTH	0.601861	0	0	0	0	0	76.00
76.01 03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.408131	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0.000000						88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000						88.01
91.00 09100 EMERGENCY	1.203580	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.828576	0	0	0	0	0	92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0.333423						95.00
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: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/25/2014 3:25 pm
		Component CCN: 14Z313	Title XVIII	Swing Beds - SNF
		Costs		Cost

Cost Center Description	Costs				5.00	5.01	6.00	7.00	
	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.)					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0				95.00
200.00		Subtotal (see instructions)	0	0	0	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	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/25/2014 3:25 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,514	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		888	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.		9	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		708	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		148	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)		444	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		11	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)		23	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		532	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)		146	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)		438	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)		4	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		121.01	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		121.01	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,708,945	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)		1,331	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)		2,783	25.00
26.00	Total swing-bed cost (see instructions)		1,086,047	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,622,898	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		924,955	28.00
29.00	Private room charges (excluding swing-bed charges)		15,675	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		909,280	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.754570	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,741.67	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,284.29	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		457.38	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		802.51	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		7,223	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,615,675	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)		1,819.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		967,947	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		3,210	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		971,157	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/25/2014 3:25 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					617,717	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,588,874	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)					265,640	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					796,919	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,062,559	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)					171	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,827.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					312,518	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141313

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

Worksheet D-1
Date/Time Prepared:
2/25/2014 3:25 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/25/2014 3:25 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		766,658		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.627730	72,737	45,659	50.00
53.00	05300 ANESTHESIOLOGY	0.555728	48,212	26,793	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.263216	157,113	41,355	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.356129	21,993	7,832	54.01
56.00	05600 RADIOISOTOPE	0.310927	5,852	1,820	56.00
58.00	05800 MRI	0.148959	6,411	955	58.00
60.00	06000 LABORATORY	0.285294	342,895	97,826	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.957870	37,321	35,749	62.00
64.00	06400 INTRAVENOUS THERAPY	0.041061	14,244	585	64.00
66.00	06600 PHYSICAL THERAPY	0.617103	60,301	37,212	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.491518	37,964	18,660	67.00
68.00	06800 SPEECH PATHOLOGY	1.813448	836	1,516	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	0.573004	161,099	92,310	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.552795	177,700	98,232	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.897414	123,926	111,213	73.00
76.00	03020 OP SENIOR HEALTH	0.601861	0	0	76.00
76.01	03021 TELEMEDICINE-PSYCHIATRIC SERVICES	0.408131	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	1.203580	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.828576	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,268,604	617,717	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,268,604		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 14Z313		Date/Time Prepared: 2/25/2014 3:25 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.627730	0	50.00
53.00	05300	ANESTHESIOLOGY	0.555728	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.263216	25,400	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.356129	1,859	54.01
56.00	05600	RADIOISOTOPE	0.310927	0	56.00
58.00	05800	MRI	0.148959	3,122	58.00
60.00	06000	LABORATORY	0.285294	101,122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.957870	1,550	62.00
64.00	06400	INTRAVENOUS THERAPY	0.041061	11,650	64.00
66.00	06600	PHYSICAL THERAPY	0.617103	142,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.491518	111,873	67.00
68.00	06800	SPEECH PATHOLOGY	1.813448	1,679	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.573004	48,260	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.552795	47,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.897414	153,804	73.00
76.00	03020	OP SENIOR HEALTH	0.601861	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.408131	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
91.00	09100	EMERGENCY	1.203580	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.828576	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		650,510	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)		650,510	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/25/2014 3:25 pm
		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)		5,204,141	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)		5,204,141	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,256,182	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		42,428	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,625,796	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)		3,587,958	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)		3,587,958	30.00
31.00	Primary payer payments		43	31.00
32.00	Subtotal (line 30 minus line 31)		3,587,915	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)		400,544	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		352,479	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		369,738	36.00
37.00	Subtotal (see instructions)		3,940,394	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)		3,940,394	40.00
40.01	Sequestration adjustment (see instructions)		39,404	40.01
41.00	Interim payments		3,852,439	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		48,551	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141313

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,348,152		3,852,439	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,348,152		3,852,439	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		98,615		48,551	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,446,767		3,900,990	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: 141313
Component CCN: 14Z313

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

Worksheet E-1
Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,318,746		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,318,746		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		104,317		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,423,063		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 FOR HIT

Provider CCN: 141313

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

Worksheet E-1
Part II
Date/Time Prepared:
2/25/2014 3:25 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			283 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			532 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			18 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			717 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			32,567,733 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			759,622 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			97,260 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			95,869 8.00
9.00	Sequestration adjustment amount (see instructions)			1,917 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			93,952 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			93,952 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141313	Period:	Worksheet E-2
		Component CCN: 14Z313	From 10/01/2012 To 09/30/2013	Date/Time Prepared: 2/25/2014 3:25 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,073,185	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
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)		380,384	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		584	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,453,569	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		1,453,569	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		1,453,569	0
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		16,132	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,437,437	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		1,437,437	0
19.01	Sequestration adjustment (see instructions)		14,374	0
20.00	Interim payments		1,318,746	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		104,317	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/25/2014 3:25 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,588,874 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,588,874 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,604,763 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,604,763 19.00
20.00	Deductibles (exclude professional component)			183,584 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,421,179 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,421,179 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			45,684 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			40,202 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			44,356 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,461,381 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,461,381 30.00
30.01	Sequestration adjustment (see instructions)			14,614 30.01
31.00	Interim payments			1,348,152 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			98,615 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 141313

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

Worksheet G

Date/Time Prepared:
2/25/2014 3:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,941,500	0	0	0	1.00
2.00	Temporary investments	482,537	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,285,068	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	379,722	0	0	0	7.00
8.00	Prepaid expenses	127,850	0	0	0	8.00
9.00	Other current assets	200,381	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,417,058	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,078,674	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,078,674	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,422,176	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	339,509	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,761,685	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,257,417	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	853,428	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,338,321	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	798,673	0	0	0	40.00
41.00	Deferred income	897,864	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	356,193	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,244,479	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,642,009	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	417,984	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,059,993	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,304,472	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	8,952,945	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)	8,952,945	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,257,417	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141313

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

Worksheet G-1

Date/Time Prepared:
2/25/2014 3:25 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		9,103,263		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-150,318			2.00
3.00	Total (sum of line 1 and line 2)		8,952,945		0	3.00
4.00	PY ADJUSTMENT	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		8,952,945		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,952,945		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	PY ADJUSTMENT		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141313

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/25/2014 3:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,011,102		2,011,102	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,011,102		2,011,102	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,011,102		2,011,102	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	0	1	1	19.00
20.00	RURAL HEALTH CLINIC	0	2,973,433	2,973,433	20.00
20.01	RURAL HEALTH CLINIC II	0	257,394	257,394	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,233,901	1,233,901	22.00
23.00	AMBULANCE SERVICES	0	1,570,421	1,570,421	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OPERATING ROOM	165,545	1,080,598	1,246,143	27.01
27.02	ANESTHESIOLOGY	76,656	701,013	777,669	27.02
27.03	RADIOLOGY-DIAGNOSTIC	249,502	5,184,914	5,434,416	27.03
27.04	RADIOLOGY-ULTRASOUND	34,549	477,646	512,195	27.04
27.05	RADIOISOTOPE	7,530	595,840	603,370	27.05
27.06	MRI	9,533	813,211	822,744	27.06
27.07	LABORATORY	638,567	5,960,988	6,599,555	27.07
27.08	INTRAVENOUS THERAPY	60,337	376,238	436,575	27.08
27.09	PHYSICAL THERAPY	227,446	1,197,950	1,425,396	27.09
27.10	OCCUPATIONAL THERAPY	164,094	391,776	555,870	27.10
27.11	SPEECH PATHOLOGY	3,082	11,225	14,307	27.11
27.12	CARDIOPULMONARY	432,854	1,628,406	2,061,260	27.12
27.13	MEDICAL SUPPLIES CHARGED	50,194	150,957	201,151	27.13
27.14	DRUGS CHARGED TO PATIENTS	340,297	765,765	1,106,062	27.14
27.16	OP SENIOR PSYCH	0	1,192,690	1,192,690	27.16
27.17	TELEMEDICINE PSYCH	0	54,235	54,235	27.17
27.18	EMERGENCY	18,215	4,060,556	4,078,771	27.18
27.21	FITNESS CENTER	0	16,423	16,423	27.21
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,489,504	30,695,582	35,185,086	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,184,458		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	CONTRIBUTION EXP	62,664			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)		62,664		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	EMPLOYEE PHYSICALS	2,516			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)		2,516		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,244,606		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141313

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

Worksheet G-3

Date/Time Prepared:
2/25/2014 3:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,185,086	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,363,225	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,821,861	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,244,606	4.00
5.00	Net income from service to patients (line 3 minus line 4)	577,255	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	134,144	6.00
7.00	Income from investments	48,009	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	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	857,816	23.00
24.00	OTHER REVENUE	542,457	24.00
24.01	GRANT REVENUE	15,000	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	260,167	24.02
24.03	REV ROUNDING	110	24.03
25.00	Total other income (sum of lines 6-24)	1,857,703	25.00
26.00	Total (line 5 plus line 25)	2,434,958	26.00
27.00	BAD DEBTS	1,766,079	27.00
27.01	CHARITY CARE	819,197	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	2,585,276	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-150,318	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313

Period: From 10/01/2012

Worksheet H

HHA CCN: 147202

To 09/30/2013

Date/Time Prepared: 2/25/2014 3:25 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	93,417	6,551	34,361	0	35,874	170,203	5.00
HHA REIMBURSABLE SERVICES							
6.00	390,880	27,412	0	0	0	418,292	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	728	51	0	0	0	779	10.00
11.00	14,189	995	0	0	0	15,184	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	499,214	35,009	34,361	0	35,874	604,458	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	170,203	-3,022	167,181			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	418,292	0	418,292			6.00
7.00	0	0	0	0			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	779	0	779			10.00
11.00	0	15,184	0	15,184			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	604,458	-3,022	601,436			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/25/2014 3:25 pm
		HHA CCN: 147202	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bl dgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	167,181	0	0	0	167,181	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	418,292	0	0	0	418,292	6.00	
7.00	Physical Therapy	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	779	0	0	0	779	10.00	
11.00	Home Health Aide	15,184	0	0	0	15,184	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	601,436	0	0	0	601,436	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	167,181					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	161,035	579,327				6.00	
7.00	Physical Therapy	0	0				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	300	1,079				10.00	
11.00	Home Health Aide	5,846	21,030				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		601,436				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141313

Period:

Worksheet H-1

HHA CCN: 147202

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

Part II
Date/Time Prepared:
2/25/2014 3:25 pm

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-167,181	434,255 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	418,292 6.00
7.00	Physical Therapy	0	0	0	0	0	0 7.00
8.00	Occupational Therapy	0	0	0	0	0	0 8.00
9.00	Speech Pathology	0	0	0	0	0	0 9.00
10.00	Medical Social Services	0	0	0	0	0	779 10.00
11.00	Home Health Aide	0	0	0	0	0	15,184 11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0 12.00
13.00	Drugs	0	0	0	0	0	0 13.00
14.00	DME	0	0	0	0	0	0 14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0 15.00
16.00	Respiratory Therapy	0	0	0	0	0	0 16.00
17.00	Private Duty Nursing	0	0	0	0	0	0 17.00
18.00	Clinic	0	0	0	0	0	0 18.00
19.00	Health Promotion Activities	0	0	0	0	0	0 19.00
20.00	Day Care Program	0	0	0	0	0	0 20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0 21.00
22.00	Homemaker Service	0	0	0	0	0	0 22.00
23.00	All Others (specify)	0	0	0	0	0	0 23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-167,181	434,255 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		167,181 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.384983 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 147202

To 09/30/2013

Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT	
		HHA Trial Balance (1)	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP		
		0	1.00	1.01	1.02	2.00		
1.00	Administrative and General	0	0	6,108	0	8,137	88,123	1.00
2.00	Skilled Nursing Care	579,327	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,079	0	0	0	0	0	6.00
7.00	Home Health Aide	21,030	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	601,436	0	6,108	0	8,137	88,123	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	102,368	15,093	117,461	0	13,141	0	1.00
2.00	Skilled Nursing Care	579,327	85,417	664,744	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,079	159	1,238	0	0	0	6.00
7.00	Home Health Aide	21,030	3,101	24,131	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	703,804	103,770	807,574	0	13,141	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		0.000000				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

Worksheet H-2

HHA CCN: 147202

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

Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Home Health
Agency I

PPS

Cost Center Description		OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	49	10,956	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	49	10,956	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	17,468	0	159,075	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	664,744	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	1,238	0	6.00
7.00	Home Health Aide	0	0	0	0	24,131	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	17,468	0	849,188	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

Worksheet H-2

HHA CCN: 147202

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

Part I
Date/Time Prepared:
2/25/2014 3:25 pm

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Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		26.00	27.00	28.00		
1.00	Administrative and General	159,075				1.00
2.00	Skilled Nursing Care	664,744	153,228	817,972		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	1,238	285	1,523		6.00
7.00	Home Health Aide	24,131	5,562	29,693		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	849,188	159,075	849,188		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.230506			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313
HHA CCN: 147202

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

Worksheet H-2
Part II
Date/Time Prepared:
2/25/2014 3:25 pm

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	1.02	2.00			
1.00	Administrative and General	0	1,594	0	8,137	499,214	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,594	0	8,137	499,214	0	20.00
21.00	Total cost to be allocated	0	6,108	0	8,137	88,123	0	21.00
22.00	Unit cost multiplier	0.000000	3.831870	0.000000	1.000000	0.176523	0	22.00
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	102,368	-117,461	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	579,327	-664,744	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,079	-1,238	0	0	0	0	6.00
7.00	Home Health Aide	21,030	-24,131	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	703,804	0	0	1,594	0	0	20.00
21.00	Total cost to be allocated	103,770	0	0	13,141	0	0	21.00
22.00	Unit cost multiplier	0.147442		0.000000	8.244040	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 141313 HHA CCN: 147202	Period: From 10/01/2012 To 09/30/2013	Worksheet H-2 Part II Date/Time Prepared: 2/25/2014 3:25 pm
			Home Health Agency I	PPS

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	29	1,594	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	29	1,594	0	0	0	0	20.00
21.00	Total cost to be allocated	49	10,956	0	0	0	0	21.00
22.00	Unit cost multiplier	1.689655	6.873275	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	1,233,901	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19)	0	1,233,901	0				20.00
21.00	Total cost to be allocated	0	17,468	0				21.00
22.00	Unit cost multiplier	0.000000	0.014157	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/25/2014 3:25 pm		
				HHA CCN: 147202	Title XVIII	Home Health Agency I	PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	817,972		817,972	8,168	100.14	1.00
2.00	Physical Therapy	3.00	0	164,475	164,475	2,903	56.66	2.00
3.00	Occupational Therapy	4.00	0	57,465	57,465	1,538	37.36	3.00
4.00	Speech Pathology	5.00	0	12,609	12,609	69	182.74	4.00
5.00	Medical Social Services	6.00	1,523		1,523	50	30.46	5.00
6.00	Home Health Aide	7.00	29,693		29,693	758	39.17	6.00
7.00	Total (sum of lines 1-6)		849,188	234,549	1,083,737	13,486		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00		4.00 5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	1,444	1,229			8.00
9.00	Physical Therapy		99914	483	289			9.00
10.00	Occupational Therapy		99914	254	130			10.00
11.00	Speech Pathology		99914	15	4			11.00
12.00	Medical Social Services		99914	4	3			12.00
13.00	Home Health Aide		99914	148	118			13.00
14.00	Total (sum of lines 8-13)			2,348	1,773			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	4,951	4,951	8,956	0.552814	15.00
16.00	Cost of Drugs	9.00	0	652	652	726	0.898072	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	Part B		Cost of Services		Part B		
	6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	1,444	1,229		144,602	123,072		1.00
2.00	Physical Therapy	483	289		27,367	16,375		2.00
3.00	Occupational Therapy	254	130		9,489	4,857		3.00
4.00	Speech Pathology	15	4		2,741	731		4.00
5.00	Medical Social Services	4	3		122	91		5.00
6.00	Home Health Aide	148	118		5,797	4,622		6.00
7.00	Total (sum of lines 1-6)	2,348	1,773		190,118	149,748		7.00
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313

Period: From 10/01/2012

Worksheet H-3

HHA CCN: 147202

To 09/30/2013

Part I
Date/Time Prepared:
2/25/2014 3:25 pm

Title XVII I

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Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies						15.00	
16.00	Cost of Drugs	269	0		242	0	16.00	
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	267,674					1.00	
2.00	Physical Therapy	43,742					2.00	
3.00	Occupational Therapy	14,346					3.00	
4.00	Speech Pathology	3,472					4.00	
5.00	Medical Social Services	213					5.00	
6.00	Home Health Aide	10,419					6.00	
7.00	Total (sum of lines 1-6)	339,866					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313

Period:

Worksheet H-3

HHA CCN: 147202

From 10/01/2012

Part II

To 09/30/2013

Date/Time Prepared:

Title XVIII

Home Health Agency I

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.617103	266,528	164,475	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.491518	116,913	57,465	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	1.813448	6,953	12,609	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.552795	8,956	4,951	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.897414	726	652	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 141313 HHA CCN: 147202	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-II Date/Time Prepared: 2/25/2014 3:25 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	242	0
2.00	Total charges	0	269	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	269	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	27	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	242
11.00	Total PPS Reimbursement - Full Episodes without Outliers		290,676	213,495
12.00	Total PPS Reimbursement - Full Episodes with Outliers		6,426	2,701
13.00	Total PPS Reimbursement - LUPA Episodes		5,205	7,096
14.00	Total PPS Reimbursement - PEP Episodes		0	0
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,228	391
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		303,535	223,925
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		303,535	223,925
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		303,535	223,925
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		303,535	223,925
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		303,535	223,925
31.01	Sequestration adjustment (see instructions)		2,791	1,996
32.00	Interim payments (see instructions)		300,744	221,840
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	89
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 141313

Period: From 10/01/2012

Worksheet H-5

HHA CCN: 147202

To 09/30/2013

Date/Time Prepared: 2/25/2014 3:25 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		300,744		221,840	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		300,744		221,840	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,791		2,085	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		303,535		223,925	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/25/2014 3:25 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,310,390	0	1,310,390	-88,532	1,221,858	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	305,577	0	305,577	0	305,577	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	478,910	0	478,910	0	478,910	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,094,877	0	2,094,877	-88,532	2,006,345	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	18,051	18,051	0	18,051	13.00
14.00	Subtotal (sum of lines 11-13)	0	18,051	18,051	0	18,051	14.00
15.00	Medical Supplies	0	24,722	24,722	0	24,722	15.00
16.00	Transportation (Health Care Staff)	0	1,031	1,031	0	1,031	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	128,278	128,278	0	128,278	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	154,031	154,031	0	154,031	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,094,877	172,082	2,266,959	-88,532	2,178,427	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	1,333	1,333	0	1,333	29.00
30.00	Administrative Costs	344,516	347,413	691,929	0	691,929	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	344,516	348,746	693,262	0	693,262	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,439,393	520,828	2,960,221	-88,532	2,871,689	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/25/2014 3:25 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,221,858
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	305,577
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	478,910
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	2,006,345
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	18,051
14.00	Subtotal (sum of lines 11-13)	0	18,051
15.00	Medical Supplies	0	24,722
16.00	Transportation (Health Care Staff)	0	1,031
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	128,278
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	154,031
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,178,427
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	1,333
30.00	Administrative Costs	-3,316	688,613
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,316	689,946
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,316	2,868,373

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/25/2014 3:25 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	59,210	0	59,210	0	59,210	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	93,637	0	93,637	0	93,637	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	5,422	0	5,422	0	5,422	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)	158,269	0	158,269	0	158,269	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	2,416	2,416	0	2,416	13.00
14.00	Subtotal (sum of lines 11-13)	0	2,416	2,416	0	2,416	14.00
15.00	Medical Supplies	0	1,556	1,556	0	1,556	15.00
16.00	Transportation (Health Care Staff)	0	5,309	5,309	0	5,309	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	6,865	6,865	0	6,865	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	158,269	9,281	167,550	0	167,550	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	6,336	6,336	0	6,336	29.00
30.00	Administrative Costs	90,376	43,418	133,794	0	133,794	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	90,376	49,754	140,130	0	140,130	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	248,645	59,035	307,680	0	307,680	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/25/2014 3:25 pm
		Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	59,210
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	93,637
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	5,422
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	158,269
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	2,416
14.00	Subtotal (sum of lines 11-13)	0	2,416
15.00	Medical Supplies	0	1,556
16.00	Transportation (Health Care Staff)	0	5,309
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	6,865
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	167,550
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	6,336
30.00	Administrative Costs	-1,355	132,439
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,355	138,775
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,355	306,325

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet M-2 Date/Time Prepared: 2/25/2014 3:25 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.93	9,255	4,200	12,306	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.99	4,874	2,100	6,279	3.00
4.00	Subtotal (sum of lines 1-3)	5.92	14,129		18,585	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)	5.92	14,129		18,585	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				2,178,427	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,178,427	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)				689,946	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,313,157	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,003,103	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				2,003,103	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				2,003,103	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				4,181,530	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet M-2		
		Component CCN: 143462		Date/Time Prepared: 2/25/2014 3:25 pm		
			Rural Health Clinic (RHC) II	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.39	754	4,200	1,638	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.01	1,019	2,100	2,121	3.00
4.00	Subtotal (sum of lines 1-3)	1.40	1,773		3,759	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.40	1,773		3,759	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)				167,550	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)				167,550	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)				138,775	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				100,342	15.00
16.00	Total overhead (sum of lines 14 and 15)				239,117	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				239,117	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				239,117	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				406,667	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet M-3
		Component CCN: 143457		Date/Time Prepared: 2/25/2014 3:25 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		4,181,530	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,181,530	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		18,585	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)		18,585	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		224.99	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	224.99	224.99	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,132	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,154,649	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	36	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	8,100	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	6,581	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,161,230	16.00
16.01	Total program charges (see instructions)(from contractor's records)		808,013	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,304	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,874	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.)		867,411	16.04
16.05	Total program cost (see instructions)		869,285	16.05
17.00	Primary payer amounts		419	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		75,092	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		146,866	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		868,866	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		868,866	22.00
23.00	Allowable bad debts (see instructions)		39,252	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		34,542	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		39,252	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		903,408	26.00
26.01	Sequestration adjustment (see instructions)		9,034	26.01
27.00	Interim payments		803,180	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		91,194	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2012 To 09/30/2013	Worksheet M-3
		Component CCN: 143462		Date/Time Prepared: 2/25/2014 3:25 pm
		Title XVIIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		406,667	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		406,667	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,759	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,759	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		108.18	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	108.18	108.18	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	32,021	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		32,021	16.00
16.01	Total program charges (see instructions)(from contractor's records)		46,910	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.)		20,730	16.04
16.05	Total program cost (see instructions)		20,730	16.05
17.00	Primary payer amounts		25	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,108	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,160	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		20,705	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		20,705	22.00
23.00	Allowable bad debts (see instructions)		1,789	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,574	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,789	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		22,279	26.00
26.01	Sequestration adjustment (see instructions)		223	26.01
27.00	Interim payments		20,659	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		1,397	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2012 To 09/30/2013	Worksheet M-5 Date/Time Prepared: 2/25/2014 3:25 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		701,480	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		04/11/2013	101,700	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		101,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		803,180	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		91,194	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		894,374	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2012 To 09/30/2013	Worksheet M-5 Date/Time Prepared: 2/25/2014 3:25 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		20,659	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		20,659	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		1,397	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		22,056	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00