

Hannibal Regional Hospital

Medicare Cost Report

Fiscal Year Ended 9.30.2013

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/27/2014 3:58 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/27/2014 Time: 3:58 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANNIBAL REGIONAL HOSPITAL (260025) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/27/2014 Time: 3:58 pm
AJSEqbg3b1j 2pbDR2ZRfDRffa67a80
TK3l t0j Znc25c4SyGc. CH25YAGqu8q
oSeK1R.0B1097xn3
PI: Date: 2/27/2014 Time: 3:58 pm
HIRHI5in0e:6dE8XEutnnv31upUJ:0
y7lUD0esFoENna0: vJHT: sBLzPCni
5rk60TLZuN02eFY4

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-255,938	-139,465	30,013	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	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		14,305		0	10.00
10.01 RURAL HEALTH CLINIC II	0		8,921		0	10.01
10.02 RURAL HEALTH CLINIC III	0		21,051		0	10.02
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-255,938	-95,188	30,013	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: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 2:08 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: HI GHWAY 36, 6000 HOSPITAL DRIVE			PO Box:						1.00		
2.00	City: HANNI BAL		State: MO		Zip Code: 63401		County: MARI ON			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			
Hospital and Hospital -Based Component Identification:												
3.00	Hospital		HANNI BAL REGIONAL HOSPITAL		260025	99926	1	01/01/1966	N	P	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											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		HANNI BAL REGIONAL - HHA		267282	99926		04/10/1990	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		HANNI BAL REG - SHELBI NA		268512	99926		06/11/1997	N	O	O	15.00
15.01	Hospital -Based Health Clinic - RHC II		HANNI BAL REG - LAGRANGE		263984	99926		04/03/1992	N	O	O	15.01
15.02	Hospital -Based Health Clinic - RHC III		HANNI BAL REG - MONROE CITY		268513	99926		06/11/1997	N	O	O	15.02
16.00	Hospital -Based Health Clinic - FOHC											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)						2		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.		1,255	348	36	0	1,403		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.						1		35.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 2:08 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2012	09/30/2013		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)	N			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		
61.02	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		
61.03	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		
61.04	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		
61.05	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		
61.06	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		
		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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name 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	4.00	5.00		
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)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						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)					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
		1.00	2.00	3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			Y			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:	162,370	0	0			118.01
		1.00	2.00				
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y	Y			120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y				121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 2:08 pm		
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		
165.00	Multi campus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N 165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00 166.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y 167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0 168.00	
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)						1.00 169.00	
						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)						07/02/2013	09/30/2013 170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 2:08 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)		Y	01/10/2014	Y
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)		N		N
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 2:08 pm
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	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.	0	1.00	2.00	3.00	21.00
		N			N	
				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					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					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.					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.					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.					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.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	JIM		MCKAKI N		41.00
42.00	Enter the employer/company name of the cost report preparer.	HANNIBAL REGIONAL HEALTHCARE SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	573-248-5431		JIM.MCKAKI N@HRHONLINE.ORG		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)	01/10/2014		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)			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.		GROUP DIRECTOR - FISCAL SERVICES	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: 260025

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	83	30,295	0.00	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)		83	30,295	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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	43.00				0	13.00
14.00 Total (see instructions)		91	33,215	0.00	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	99.00				0	25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		91				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: 260025

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,179	970	14,254			1.00
2.00 HMO and other (see instructions)	626	1,751				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,179	970	14,254			7.00
8.00 INTENSIVE CARE UNIT	1,306	221	2,075			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		88	1,375			13.00
14.00 Total (see instructions)	10,485	1,279	17,704	0.00	772.43	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	3,522	0	6,352	0.00	12.16	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	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC	1,447	197	4,851	0.00	9.43	26.00
26.01 RURAL HEALTH CLINIC II	1,243	733	4,529	0.00	6.57	26.01
26.02 RURAL HEALTH CLINIC III	1,553	202	5,069	0.00	7.80	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	808.39	27.00
28.00 Observation Bed Days		0	708			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		12	176			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: 260025

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	2,369	270	4,476	1.00
2.00 HMO and other (see instructions)				153			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	2,369	270	4,476		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	0.00						25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.01 RURAL HEALTH CLINIC II	0.00						26.01
26.02 RURAL HEALTH CLINIC III	0.00						26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 260025

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

Worksheet S-3
Part II
Date/Time Prepared:
2/27/2014 2:08 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	49,902,014	0	49,902,014	1,681,433.00	29.68
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		112,617	0	112,617	574.00	196.20
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		4,025,254	0	4,025,254	29,141.00	138.13
6.00	Non-physician-Part B		929,871	0	929,871	41,879.00	22.20
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		12,000,396	-250,660	11,749,736	287,421.00	40.88
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		538,923	0	538,923	7,397.00	72.86
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		769,500	0	769,500	2,609.00	294.94
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,286,439	0	13,286,439		17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0		18.00
19.00	Excluded areas		2,887,740	0	2,887,740		19.00
20.00	Non-physician anesthesiologist Part A		0	0	0		20.00
21.00	Non-physician anesthesiologist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		5,762	0	5,762		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		292,782	0	292,782		23.00
24.00	Wage-related costs (RHC/FQHC)		420,761	0	420,761		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	509,140	250,660	759,800	38,776.00	19.59
27.00	Administrative & General	5.00	8,589,470	0	8,589,470	296,922.00	28.93
28.00	Administrative & General under contract (see inst.)		1,110,406	0	1,110,406	6,614.00	167.89
29.00	Maintenance & Repairs	6.00	264,246	0	264,246	18,225.00	14.50
30.00	Operation of Plant	7.00	626,611	0	626,611	30,064.00	20.84
31.00	Laundry & Linen Service	8.00	30,701	0	30,701	3,146.00	9.76
32.00	Housekeeping	9.00	614,737	0	614,737	53,291.00	11.54
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	765,482	0	765,482	55,476.00	13.80
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	616,902	0	616,902	20,944.00	29.45
39.00	Central Services and Supply	14.00	126,171	0	126,171	7,774.00	16.23
40.00	Pharmacy	15.00	1,549,797	0	1,549,797	40,224.00	38.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 260025

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

Worksheet S-3
Part II
Date/Time Prepared:
2/27/2014 2:08 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	681,034	0	681,034	37,744.00	18.04	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 260025

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

Worksheet S-3
Part III
Date/Time Prepared:
2/27/2014 2:08 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	46,057,295	0	46,057,295	1,617,027.00	28.48	1.00
2.00	Excluded area salaries (see instructions)	12,000,396	-250,660	11,749,736	287,421.00	40.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,056,899	250,660	34,307,559	1,329,606.00	25.80	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,308,423	0	1,308,423	10,006.00	130.76	4.00
5.00	Subtotal wage-related costs (see inst.)	13,292,201	0	13,292,201	0.00	38.74	5.00
6.00	Total (sum of lines 3 thru 5)	48,657,523	250,660	48,908,183	1,339,612.00	36.51	6.00
7.00	Total overhead cost (see instructions)	15,484,697	250,660	15,735,357	609,200.00	25.83	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2014 2:08 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,755,441 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			1,744,467 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			8,426,985 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			-16,995 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			57,311 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			147,243 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			25,395 14.00
15.00	'Workers' Compensation Insurance			401,821 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			3,117,782 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			48,312 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			39,607 22.00
23.00	Tuition Reimbursement			146,115 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			16,893,484 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 260025

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

Worksheet S-3
Part V
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	684,173	16,893,484	1.00
2.00	Hospital	684,173	13,292,201	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	177,687	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	420,761	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FOHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	3,002,835	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 260025 Component CCN: 267282		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/27/2014 2:08 pm		
				Home Health Agency I		PPS		
				1.00				
0.00	County	MARION				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	3,578	0	411	3,989	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	261.00	21.00	178.00	460.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00	
4.00	Director(s) and Assistant Director(s)			3.05	0.00	3.05	4.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00	
6.00	Direct Nursing Service			4.75	0.00	4.75	6.00	
7.00	Nursing Supervisor			2.01	0.00	2.01	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			0.08	0.00	0.08	11.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00	
13.00	Speech Pathology Supervisor			0.03	0.00	0.03	13.00	
14.00	Medical Social Service			0.00	0.00	0.00	14.00	
15.00	Medical Social Service Supervisor			1.92	0.00	1.92	15.00	
16.00	Home Health Aide			0.00	0.00	0.00	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.			2			19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99926			20.00	
20.01				99914			20.01	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	1,614	127	69	29	1,839	21.00	
22.00	Skilled Nursing Visit Charges	234,030	18,415	0	4,205	256,650	22.00	
23.00	Physical Therapy Visits	1,099	14	12	26	1,151	23.00	
24.00	Physical Therapy Visit Charges	170,345	2,170	1,860	4,030	178,405	24.00	
25.00	Occupational Therapy Visits	0	0	0	0	0	25.00	
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00	
27.00	Speech Pathology Visits	58	0	0	4	62	27.00	
28.00	Speech Pathology Visit Charges	8,990	0	0	620	9,610	28.00	
29.00	Medical Social Service Visits	5	0	0	2	7	29.00	
30.00	Medical Social Service Visit Charges	775	0	0	310	1,085	30.00	
31.00	Home Health Aide Visits	367	81	0	15	463	31.00	
32.00	Home Health Aide Visit Charges	25,690	5,670	0	1,050	32,410	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,143	222	81	76	3,522	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)	439,830	26,255	1,860	10,215	478,160	35.00	
36.00	Total Number of Episodes (standard/non outlier)	248		24	4	276	36.00	
37.00	Total Number of Outlier Episodes		4		1	5	37.00	
38.00	Total Non-Routine Medical Supply Charges	18,733	2,563	723	216	22,235	38.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 268512		Period: From 10/01/2012 To 09/30/2013		Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		400 S. CENTER STREET				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		SHELBI NA		MO		63468 2.00	
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	
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)							
11.00 Clinic		08:00		17:00		08:00 11.00	
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		SHELBI NA FAMILY PRACTICE		268512		14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0		0		0 15.00	
2.00							
County							
4.00							
2.00 City, State, Zip Code, County		SHELBY				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)							
11.00 Clinic		17:00		08:00		17:00 08:00 17:00 11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm Cost
		Rural Health Clinic (RHC) I	

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

Facility hours of operations (1)

Clinic

08:00

17:00

08:00

12:00

11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm		
			Rural Health Clinic (RHC) II	Cost		
1.00 Clinic Address and Identification						
Street			1802 ELM STREET		1.00	
City			State	Zip Code		
1.00 CANTON			2.00 MO	3.00 63435	2.00	
2.00 City, State, Zip Code, County						
3.00 FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						
				Grant Award	Date	
				1.00	2.00	
4.00 Source of Federal Funds						
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	
10.00 Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)						
			1.00 N	2.00 0	10.00	
11.00 Facility hours of operations (1)						
Clinic						
		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
		08:00		17:00		
		08:00		08:00		
12.00 Have you received an approval for an exception to the productivity standard?						
			1.00 N	2.00 0	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.						
			1.00 N	2.00 0	13.00	
14.00 Provider name, CCN number						
			Provider name		CCN number	
			1.00 CANTON-LAGRANGE MEDICAL CLINIC		2.00 263984	
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)						
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00 0	3.00 0	4.00 0	5.00 0
2.00 City, State, Zip Code, County						
			County			
			4.00 LEWIS		2.00	
11.00 Facility hours of operations (1)						
Clinic						
		Tuesday	Wednesday		Thursday	
		to	from	to	from	
		6.00	7.00	8.00	9.00	
		17:00		08:00		
		08:00		17:00		

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm Cost
		Rural Health Clinic (RHC) II	

	Friday		Saturday			
	from	to	from	to		
	11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) Clinic					
	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm	
			Rural Health Clinic (RHC) III	Cost	
1.00					
Clinic Address and Identification					
1.00	Street	821 BUSINESS HWYS 24 & 36		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	MONROE CITY		MO63456 2.00	
3.00					
FQHCs 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 FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
Sunday Monday Tuesday					
		from	to	from	to
		1.00	2.00	3.00	4.00
				from	
				5.00	
11.00	Facility hours of operations (1) Clinic	08:00		17:00 08:00 11.00	
1.00 2.00					
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 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	MONROE CITY FAMILY PRACTICE		268513 14.00	
		XVIII	XIX	Total Visits	
		1.00	2.00	3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	0		0 15.00	
County					
4.00					
2.00	City, State, Zip Code, County	MONROE		2.00	
Tuesday Wednesday Thursday					
		to	from	to	to
		6.00	7.00	8.00	9.00 10.00
11.00	Facility hours of operations (1) Clinic	17:00 08:00		17:00 08:00 17:00 11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/27/2014 2:08 pm Cost
		Rural Health Clinic (RHC) III	

	Friday		Saturday			
	from	to	from	to		
	11.00	08:00	17:00	13:00		

Facility hours of operations (1)

Clinic

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/27/2014 2:08 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)		0.323319		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		7,929,936		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?		N		4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,970,718		5.00	
6.00	Medicaid charges		30,891,668		6.00	
7.00	Medicaid cost (line 1 times line 6)		9,987,863		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		0		9.00	
10.00	Stand-alone SCHIP charges		0		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,856,564	1,172,408	7,028,972	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,893,538	379,062	2,272,600	21.00	
22.00	Partial payment by patients approved for charity care	64,184	17,443	81,627	22.00	
23.00	Cost of charity care (line 21 minus line 22)	1,829,354	361,619	2,190,973	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,127,373		26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		542,734		27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		6,584,639		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,128,939		29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		4,319,912		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,319,912		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet A	
Date/Time Prepared: 2/27/2014 2:08 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		3,130,025	3,130,025	1,007,619	4,137,644	1.00
2.00	00200		5,370,938	5,370,938	-1,722,927	3,648,011	2.00
4.00	00400		10,685,228	11,194,368	290,267	11,484,635	4.00
5.00	00500	509,140	9,356,765	17,946,235	-553,197	17,393,038	5.00
6.00	00600	264,246	59,040	323,286	0	323,286	6.00
7.00	00700	626,611	1,511,212	2,137,823	0	2,137,823	7.00
8.00	00800	30,701	260,850	291,551	0	291,551	8.00
9.00	00900	614,737	195,830	810,567	0	810,567	9.00
10.00	01000	765,482	748,937	1,514,419	0	1,514,419	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	616,902	97,940	714,842	0	714,842	13.00
14.00	01400	126,171	170,565	296,736	-12,114	284,622	14.00
15.00	01500	1,549,797	484,358	2,034,155	0	2,034,155	15.00
16.00	01600	681,034	437,631	1,118,665	0	1,118,665	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,990,683	1,416,848	6,407,531	64,426	6,471,957	30.00
31.00	03100	1,612,706	498,992	2,111,698	23,030	2,134,728	31.00
43.00	04300	325,329	135,217	460,546	5,927	466,473	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,036,044	934,503	1,970,547	0	1,970,547	50.00
51.00	05100	884,323	162,160	1,046,483	0	1,046,483	51.00
52.00	05200	821,152	189,368	1,010,520	5,156	1,015,676	52.00
53.00	05300	2,498,151	504,514	3,002,665	222,457	3,225,122	53.00
54.00	05400	1,160,185	624,307	1,784,492	517,748	2,302,240	54.00
56.00	03450	110,245	80,708	190,953	5,345	196,298	56.00
57.00	05700	209,462	181,274	390,736	172,576	563,312	57.00
58.00	05800	66,108	130,321	196,429	0	196,429	58.00
60.00	06000	1,270,646	2,111,637	3,382,283	107,901	3,490,184	60.00
62.00	06200	73,856	523,760	597,616	0	597,616	62.00
65.00	06500	742,264	235,436	977,700	26,977	1,004,677	65.00
66.00	06600	861,070	579,679	1,440,749	0	1,440,749	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	138,364	38,113	176,477	0	176,477	68.00
69.00	06900	873,184	513,585	1,386,769	0	1,386,769	69.00
70.00	07000	152,097	30,884	182,981	0	182,981	70.00
71.00	07100	0	7,462,839	7,462,839	-699,060	6,763,779	71.00
72.00	07200	0	552,294	552,294	699,060	1,251,354	72.00
73.00	07300	0	2,655,756	2,655,756	0	2,655,756	73.00
76.00	03020	736,836	633,379	1,370,215	100,731	1,470,946	76.00
76.01	03021	38,655	22,916	61,571	0	61,571	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	613,704	209,640	823,344	0	823,344	88.00
88.01	08801	462,614	109,883	572,497	0	572,497	88.01
88.02	08802	549,444	185,119	734,563	0	734,563	88.02
89.00	08900	0	0	0	0	0	89.00
91.00	09100	3,186,396	3,620,922	6,807,318	0	6,807,318	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	113,809	15,589	129,398	0	129,398	91.02
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	738,401	254,623	993,024	0	993,024	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		38,640,019	57,123,585	95,763,604	261,922	96,025,526	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	8,968,768	2,412,521	11,381,289	28,345	11,409,634	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	941,103	388,221	1,329,324	-290,267	1,039,057	194.01
194.02	07952	3,898	55,565	59,463	0	59,463	194.02
194.03	07953	585,795	86,082	671,877	0	671,877	194.03
194.04	07954	163,412	28,480	191,892	0	191,892	194.04
194.05	07955	599,019	171,392	770,411	0	770,411	194.05
194.06	07956	0	0	0	0	0	194.06
200.00		49,902,014	60,265,846	110,167,860	0	110,167,860	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 260025

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

Worksheet A
Date/Time Prepared:
2/27/2014 2:08 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	-245,755	3,891,889	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,648,011	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	668,822	12,153,457	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,112,637	23,505,675	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	323,286	6.00
7.00	00700	OPERATION OF PLANT	-14,344	2,123,479	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	291,551	8.00
9.00	00900	HOUSEKEEPING	0	810,567	9.00
10.00	01000	DIETARY	-536,142	978,277	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	714,842	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	284,622	14.00
15.00	01500	PHARMACY	0	2,034,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-55,153	1,063,512	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,000	6,465,957	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,134,728	31.00
43.00	04300	NURSERY	-1,072	465,401	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-24,575	1,945,972	50.00
51.00	05100	RECOVERY ROOM	0	1,046,483	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-108	1,015,568	52.00
53.00	05300	ANESTHESIOLOGY	-2,466,390	758,732	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-419	2,301,821	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	196,298	56.00
57.00	05700	CT SCAN	0	563,312	57.00
58.00	05800	MRI	0	196,429	58.00
60.00	06000	LABORATORY	-350,965	3,139,219	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	597,616	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,004,677	65.00
66.00	06600	PHYSICAL THERAPY	-133,928	1,306,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	-116,633	59,844	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,386,769	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-14,430	168,551	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,763,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,251,354	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,655,756	73.00
76.00	03020	CANCER CENTER	-33,034	1,437,912	76.00
76.01	03021	DIABETES CENTER	-200	61,371	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-506	822,838	88.00
88.01	08801	RURAL HEALTH CLINIC II	-756	571,741	88.01
88.02	08802	RURAL HEALTH CLINIC III	-285	734,278	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-3,745,613	3,061,705	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	91.01
91.02	09102	WOUND CARE	0	129,398	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	-32	992,992	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-964,881	95,060,645	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,409,634	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	RENTAL	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,039,057	194.01
194.02	07952	HWY 61 BUILDING	0	59,463	194.02
194.03	07953	MEDICAL BUILDING	0	671,877	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	191,892	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	770,411	194.05
194.06	07956	MENTAL HEALTH	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-964,881	109,202,979	200.00

RECLASSIFICATIONS

Provider CCN: 260025

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

Worksheet A-6

Date/Time Prepared:
2/27/2014 2:08 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - ADMISSION KITS					
1.00	ADULTS & PEDIATRICS	30.00	0	1,031	1.00
2.00	NURSERY	43.00	0	5,927	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,156	3.00
	TOTALS		0	12,114	
B - INTEREST EXP ON BONDS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,007,619	1.00
	TOTALS		0	1,007,619	
C - CAPITAL LEASE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	680,307	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	56,808	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	20,637	3.00
4.00	ANESTHESIOLOGY	53.00	0	199,344	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	463,955	5.00
6.00	NUCLEAR MEDICINE - DIAGNOSTIC	56.00	0	4,790	6.00
7.00	CT SCAN	57.00	0	154,646	7.00
8.00	LABORATORY	60.00	0	96,690	8.00
9.00	RESPIRATORY THERAPY	65.00	0	24,174	9.00
10.00	CANCER CENTER	76.00	0	90,265	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,400	11.00
	TOTALS		0	1,817,016	
D - PROPERTY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	94,089	1.00
	TOTALS		0	94,089	
E - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	699,060	1.00
	TOTALS		0	699,060	
F - CAP LEASE INTEREST					
1.00	ADULTS & PEDIATRICS	30.00	0	6,587	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,393	2.00
3.00	ANESTHESIOLOGY	53.00	0	23,113	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,793	4.00
5.00	NUCLEAR MEDICINE - DIAGNOSTIC	56.00	0	555	5.00
6.00	CT SCAN	57.00	0	17,930	6.00
7.00	LABORATORY	60.00	0	11,211	7.00
8.00	RESPIRATORY THERAPY	65.00	0	2,803	8.00
9.00	CANCER CENTER	76.00	0	10,466	9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,945	10.00
	TOTALS		0	131,796	
G - CHILDREN'S CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	250,660	39,607	1.00
	TOTALS		250,660	39,607	
500.00	Grand Total: Increases		250,660	3,801,301	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - ADMISSION KITS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,114	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	12,114			
B - INTEREST EXP ON BONDS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,007,619	11		1.00
	TOTALS		0	1,007,619			
C - CAPITAL LEASE EXP							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,817,016	9		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
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	1,817,016			
D - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	94,089	9		1.00
	TOTALS		0	94,089			
E - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	699,060	0		1.00
	TOTALS		0	699,060			
F - CAP LEASE INTEREST							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	131,796	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
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		0	131,796			
G - CHILDREN'S CENTER							
1.00	CHILD DEVELOPMENT CENTER	194.01	250,660	39,607	0		1.00
	TOTALS		250,660	39,607			
500.00	Grand Total: Decreases		250,660	3,801,301			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

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

Worksheet A-7
Part I
Date/Time Prepared:
2/27/2014 2:08 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	2,693,370	0	0	0	0	1.00
2.00	Land Improvements	7,075,128	37,635	0	37,635	0	2.00
3.00	Buildings and Fixtures	42,884,234	0	0	0	559	3.00
4.00	Building Improvements	18,304,570	174,987	0	174,987	0	4.00
5.00	Fixed Equipment	104,564	19,657	0	19,657	0	5.00
6.00	Movable Equipment	58,667,843	3,195,807	0	3,195,807	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	129,729,709	3,428,086	0	3,428,086	559	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	129,729,709	3,428,086	0	3,428,086	559	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,693,370	0				1.00
2.00	Land Improvements	7,112,763	0				2.00
3.00	Buildings and Fixtures	42,883,675	0				3.00
4.00	Building Improvements	18,479,557	0				4.00
5.00	Fixed Equipment	124,221	0				5.00
6.00	Movable Equipment	61,863,650	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	133,157,236	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	133,157,236	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

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

Worksheet A-7
Part II
Date/Time Prepared:
2/27/2014 2:08 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	3,013,058	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,370,938	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,383,996	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	116,967	3,130,025				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,370,938				2.00
3.00	Total (sum of lines 1-2)	116,967	8,500,963				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

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

Worksheet A-7
Part III
Date/Time Prepared:
2/27/2014 2:08 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	71,293,586	0	71,293,586	0.589365	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	61,863,650	12,190,362	49,673,288	0.410635	0	2.00
3.00	Total (sum of lines 1-2)	133,157,236	12,190,362	120,966,874	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	3,013,058	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,648,011	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,661,069	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	761,864	0	0	116,967	3,891,889	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,648,011	2.00
3.00	Total (sum of lines 1-2)	761,864	0	0	116,967	7,539,900	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-44,502		CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		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)	A	-8,720		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,657,025				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-536,142		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-55,153		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				OUTILIZATION REVIEW - SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			OSPEECH PATHOLOGY	68.00		31.00

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
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC INCOME	B	-11,091	ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 RECRUITMENT FEES	A	-44,782	ADMINISTRATIVE & GENERAL	5.00		0	34.00
35.00 STAFF DEVELOPMENT	B	-4,819	ADMINISTRATIVE & GENERAL	5.00		0	35.00
36.00 NON ALLOWED ADVERTISING COSTS	A	-801,351	ADMINISTRATIVE & GENERAL	5.00		0	36.00
37.00 NURSERY PHOTOS	B	-1,072	NURSERY	43.00		0	37.00
38.00 ULTRAFAST LAB TEST	B	-1,465	LABORATORY	60.00		0	38.00
39.00 MEDICAID/FRA	A	7,552,577	ADMINISTRATIVE & GENERAL	5.00		0	39.00
40.00 LOBBYING EXPENSE	A	-12,695	ADMINISTRATIVE & GENERAL	5.00		0	40.00
41.00 ALCOHOLIC BEVERAGE EXPENSE	A	-3,149	ADMINISTRATIVE & GENERAL	5.00		0	41.00
42.00 EEG CONTRACT SERVICE	B	-14,430	ELECTROENCEPHALOGRAPHY	70.00		0	42.00
43.00 P/T CONTRACT SERVICE	B	-133,928	PHYSICAL THERAPY	66.00		0	43.00
44.00 EMPLOYED PHYSICIAN BENEFITS	A	-574,105	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	44.00
45.00 DEVELOPMENT SALARIES	A	-231,626	ADMINISTRATIVE & GENERAL	5.00		0	45.00
45.01 DEVELOPMENT EXPENSE	A	-143,385	ADMINISTRATIVE & GENERAL	5.00		0	45.01
45.02 SPEECH CONTRACT SERVICE	B	-116,633	SPEECH PATHOLOGY	68.00		0	45.02
45.03 OTHER - MISC	B	-67,154	ADMINISTRATIVE & GENERAL	5.00		0	45.03
45.04 MISC REVENUE	B	-419	RADIOLOGY-DIAGNOSTIC	54.00		0	45.04
45.05 MISC REVENUE	B	-108	DELIVERY ROOM & LABOR ROOM	52.00		0	45.05
45.06 BUILDING RENTAL INCOME	B	-201,253	CAP REL COSTS-BLDG & FIXT	1.00		11	45.06
45.07 PLANT OPERATIONS OTHER REV	B	-5,624	OPERATION OF PLANT	7.00		0	45.07
45.08 CONTRIBUTIONS	A	-2,661	ADMINISTRATIVE & GENERAL	5.00		0	45.08
45.09 ADVERTISING EMPLOYEE BENEFITS	A	-50,176	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.09
45.10 FOUNDATION EMPLOYEE BENEFITS	A	-49,597	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.10
45.11 RHC-MONROE CIT OTHER REV	B	-285	RURAL HEALTH CLINIC III	88.02		0	45.11
45.12 EMERGENCY OTHER REV	B	-455	EMERGENCY	91.00		0	45.12
45.13 DEFINED BENEFIT PENSION PLAN	A	1,342,700	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.13
45.14 COMMUNICATIONS OTHER REVENUE	B	-10,568	ADMINISTRATIVE & GENERAL	5.00		0	45.14
45.15 GENERAL AND ADMINISTRATIVE OTHER REV	B	-74,290	ADMINISTRATIVE & GENERAL	5.00		0	45.15
45.16 RHC OTHER REVENUE	B	-506	RURAL HEALTH CLINIC	88.00		0	45.16
45.17 RHC -LAGRANGE OTHER REVENUE	B	-756	RURAL HEALTH CLINIC II	88.01		0	45.17
45.18 SURGERY OTHER REVENUE	B	-1	OPERATING ROOM	50.00		0	45.18
45.19 DIABETES CENTER OTHER REVENUE	B	-200	DIABETES CENTER	76.01		0	45.19
45.20 HOME HEALTH OTHER REVENUE	B	-32	HOME HEALTH AGENCY	101.00		0	45.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-964,881					50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 260025

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2014 2:08 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	5.00	ADMINISTRATIVE & GENERAL	115,188	-17,562	132,750	159,800	1,078	1.00
2.00	30.00	ADULTS & PEDIATRICS	6,000	6,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	37,500	0	37,500	182,900	147	3.00
4.00	53.00	ANESTHESIOLOGY	2,468,967	2,461,351	7,616	167,500	32	4.00
5.00	60.00	LABORATORY	400,000	0	400,000	208,000	505	5.00
6.00	76.00	CANCER CENTER	60,000	0	60,000	159,800	351	6.00
7.00	91.00	EMERGENCY	3,777,118	3,687,116	90,002	159,800	416	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			6,864,773	6,136,905	727,868		2,529	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	5.00	ADMINISTRATIVE & GENERAL	82,819	4,141	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	12,926	646	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	2,577	129	0	0	0	4.00
5.00	60.00	LABORATORY	50,500	2,525	0	0	0	5.00
6.00	76.00	CANCER CENTER	26,966	1,348	0	0	0	6.00
7.00	91.00	EMERGENCY	31,960	1,598	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			207,748	10,387	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	5.00	ADMINISTRATIVE & GENERAL	0	82,819	49,931	32,369		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	6,000		2.00
3.00	50.00	OPERATING ROOM	0	12,926	24,574	24,574		3.00
4.00	53.00	ANESTHESIOLOGY	0	2,577	5,039	2,466,390		4.00
5.00	60.00	LABORATORY	0	50,500	349,500	349,500		5.00
6.00	76.00	CANCER CENTER	0	26,966	33,034	33,034		6.00
7.00	91.00	EMERGENCY	0	31,960	58,042	3,745,158		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	207,748	520,120	6,657,025		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,891,889	3,891,889			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,648,011		3,648,011		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,153,457	0	563	12,154,020	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	23,505,675	576,076	1,718,606	2,211,221	28,011,578
6.00 00600	MAINTENANCE & REPAIRS	323,286	0	708	71,928	395,922
7.00 00700	OPERATION OF PLANT	2,123,479	343,061	57,460	170,564	2,694,564
8.00 00800	LAUNDRY & LINEN SERVICE	291,551	7,314	222	8,357	307,444
9.00 00900	HOUSEKEEPING	810,567	22,259	724	167,331	1,000,881
10.00 01000	DIETARY	978,277	85,038	9,525	208,364	1,281,204
11.00 01100	CAFETERIA	0	70,411	0	0	70,411
13.00 01300	NURSING ADMINISTRATION	714,842	13,492	71,909	167,921	968,164
14.00 01400	CENTRAL SERVICES & SUPPLY	284,622	54,512	0	34,344	373,478
15.00 01500	PHARMACY	2,034,155	48,334	5,749	421,855	2,510,093
16.00 01600	MEDICAL RECORDS & LIBRARY	1,063,512	30,890	9,669	185,377	1,289,448
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,465,957	816,266	47,170	1,356,831	8,686,224
31.00 03100	INTENSIVE CARE UNIT	2,134,728	123,923	25,078	438,979	2,722,708
43.00 04300	NURSERY	465,401	0	8,978	88,555	562,934
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,945,972	163,649	244,400	282,011	2,636,032
51.00 05100	RECOVERY ROOM	1,046,483	166,079	972	240,713	1,454,247
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,015,568	0	3,264	223,518	1,242,350
53.00 05300	ANESTHESIOLOGY	758,732	2,726	7,321	10,016	778,795
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,301,821	234,060	165,651	315,802	3,017,334
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	196,298	8,722	47,341	30,009	282,370
57.00 05700	CT SCAN	563,312	17,625	9,424	57,016	647,377
58.00 05800	MRI	196,429	13,514	1,284	17,995	229,222
60.00 06000	LABORATORY	3,139,219	121,811	54,281	345,870	3,661,181
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	597,616	2,271	431	20,104	620,422
65.00 06500	RESPIRATORY THERAPY	1,004,677	26,802	6,977	202,044	1,240,500
66.00 06600	PHYSICAL THERAPY	1,306,821	87,310	15,092	234,383	1,643,606
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	59,844	0	243	37,663	97,750
69.00 06900	ELECTROCARDIOLOGY	1,386,769	209,234	288,314	237,681	2,121,998
70.00 07000	ELECTROENCEPHALOGRAPHY	168,551	4,543	2,126	41,401	216,621
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,763,779	0	0	0	6,763,779
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,251,354	0	0	0	1,251,354
73.00 07300	DRUGS CHARGED TO PATIENTS	2,655,756	0	0	0	2,655,756
76.00 03020	CANCER CENTER	1,437,912	0	200,906	200,567	1,839,385
76.01 03021	DIABETES CENTER	61,371	0	539	10,522	72,432
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	822,838	0	2,404	97,423	922,665
88.01 08801	RURAL HEALTH CLINIC II	571,741	0	56	71,835	643,632
88.02 08802	RURAL HEALTH CLINIC III	734,278	0	4,896	83,851	823,025
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	3,061,705	634,290	233,501	632,700	4,562,196
91.01 09101	OUTPATIENT PSYCH	0	0	0	0	0
91.02 09102	WOUND CARE	129,398	0	0	30,979	160,377
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.00 04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	992,992	0	4,093	200,993	1,198,078
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
114.00 11400	UTILIZATION REVIEW - SNF	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	95,060,645	3,884,212	3,249,877	9,156,723	91,657,537
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,409,634	1,817	357,233	2,441,310	14,209,994
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	RENTAL	0	0	0	0	0
194.01 07951	CHILD DEVELOPMENT CENTER	1,039,057	0	7,609	187,939	1,234,605
194.02 07952	HWY 61 BUILDING	59,463	0	8,833	1,061	69,357
194.03 07953	MEDICAL BUILDING	671,877	0	0	159,453	831,330
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	191,892	0	0	44,481	236,373
194.05 07955	PHYSICIAN OFFICES MEXICO	770,411	0	24,459	163,053	957,923

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.06 07956 MENTAL HEALTH	0	5,860	0	0	5,860	194.06
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	109,202,979	3,891,889	3,648,011	12,154,020	109,202,979	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part I Date/Time Prepared: 2/27/2014 2:08 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,011,578					5.00
6.00	00600	MAINTENANCE & REPAIRS	136,596	532,518				6.00
7.00	00700	OPERATION OF PLANT	929,643	46,979	3,671,186			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	106,070	628	4,745	418,887		8.00
9.00	00900	HOUSEKEEPING	345,311	1,910	14,442	0	1,362,544	9.00
10.00	01000	DIETARY	442,024	7,297	55,173	0	39,447	10.00
11.00	01100	CAFETERIA	24,292	6,042	45,683	0	32,662	11.00
13.00	01300	NURSING ADMINISTRATION	334,023	1,158	8,753	0	6,258	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,853	4,678	35,368	0	25,287	14.00
15.00	01500	PHARMACY	866,000	4,147	31,359	0	22,421	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	444,869	2,651	20,042	0	14,329	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,996,808	70,043	529,600	173,183	378,643	30.00
31.00	03100	INTENSIVE CARE UNIT	939,353	10,634	80,402	25,378	57,485	31.00
43.00	04300	NURSERY	194,216	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	909,449	14,043	106,176	69,414	75,912	50.00
51.00	05100	RECOVERY ROOM	501,725	14,251	107,753	29,884	77,040	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	428,619	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	268,690	234	1,768	0	1,264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,041,001	22,686	171,533	27,120	108,574	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	97,420	748	5,659	0	4,046	56.00
57.00	05700	CT SCAN	223,350	1,512	11,436	0	8,176	57.00
58.00	05800	MRI	79,083	1,160	8,768	0	6,269	58.00
60.00	06000	LABORATORY	1,263,133	12,934	97,791	0	56,505	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	214,050	195	1,474	0	1,054	62.00
65.00	06500	RESPIRATORY THERAPY	427,981	4,857	36,723	0	12,433	65.00
66.00	06600	PHYSICAL THERAPY	567,056	10,673	80,697	1,901	40,501	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,724	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	732,104	17,954	135,753	9,678	97,058	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,736	390	2,947	2,185	2,107	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,333,551	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	431,726	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	916,254	0	0	0	0	73.00
76.00	03020	CANCER CENTER	634,601	34,692	262,310	7,333	0	76.00
76.01	03021	DIABETES CENTER	24,990	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	318,326	6,237	47,157	206	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	222,058	14,606	110,435	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	283,949	12,002	90,747	771	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,573,990	54,428	411,531	67,824	294,230	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	55,331	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	413,345	7,114	53,788	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,958,300	386,883	2,570,013	414,877	1,361,701	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	4,902,525	90,316	682,907	3,858	843	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	425,947	30,833	233,131	0	0	194.01
194.02	07952	HWY 61 BUILDING	23,929	10,905	82,451	0	0	194.02
194.03	07953	MEDICAL BUILDING	286,815	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	81,550	3,446	26,054	152	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	330,490	10,135	76,630	0	0	194.05
194.06	07956	MENTAL HEALTH	2,022	0	0	0	0	194.06
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)	28,011,578	532,518	3,671,186	418,887	1,362,544	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 2:08 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,825,145					10.00
11.00	01100	CAFETERIA	1,281,003	1,460,093				11.00
13.00	01300	NURSING ADMINISTRATION	0	28,219	1,346,575			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,481	0	578,145		14.00
15.00	01500	PHARMACY	0	54,197	0	0	3,488,217	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,862	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	474,998	291,413	912,907	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	69,144	79,950	251,078	0	0	31.00
43.00	04300	NURSERY	0	18,047	56,691	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	56,327	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	43,632	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,561	111,685	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	26,202	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,533	0	0	0	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	4,540	0	0	0	56.00
57.00	05700	CT SCAN	0	9,780	0	0	0	57.00
58.00	05800	MRI	0	3,251	0	0	0	58.00
60.00	06000	LABORATORY	0	89,758	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,811	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,457	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,581	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,473	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,232	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,043	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	508,670	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,475	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,488,217	73.00
76.00	03020	CANCER CENTER	0	20,261	0	0	0	76.00
76.01	03021	DIABETES CENTER	0	2,242	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
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	127,982	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	4,512	14,214	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,825,145	1,143,347	1,346,575	578,145	3,488,217	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	246,492	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	70,254	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	0	0	0	0	194.05
194.06	07956	MENTAL HEALTH	0	0	0	0	0	194.06
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)	1,825,145	1,460,093	1,346,575	578,145	3,488,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,822,201					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,202,627	0	15,716,446	0	15,716,446	30.00
31.00	03100	INTENSIVE CARE UNIT	236,899	0	4,473,031	0	4,473,031	31.00
43.00	04300	NURSERY	91,123	0	923,011	0	923,011	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	3,867,353	0	3,867,353	50.00
51.00	05100	RECOVERY ROOM	0	0	2,228,532	0	2,228,532	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,818,215	0	1,818,215	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,076,953	0	1,076,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,442,781	0	4,442,781	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	394,783	0	394,783	56.00
57.00	05700	CT SCAN	0	0	901,631	0	901,631	57.00
58.00	05800	MRI	0	0	327,753	0	327,753	58.00
60.00	06000	LABORATORY	0	0	5,181,302	0	5,181,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	841,006	0	841,006	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,761,951	0	1,761,951	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,379,015	0	2,379,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	137,947	0	137,947	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,153,777	0	3,153,777	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	307,029	0	307,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,606,000	0	9,606,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,752,555	0	1,752,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,060,227	0	7,060,227	73.00
76.00	03020	CANCER CENTER	0	0	2,798,582	0	2,798,582	76.00
76.01	03021	DIABETES CENTER	0	0	99,664	0	99,664	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,294,591	0	1,294,591	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	990,731	0	990,731	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,210,494	0	1,210,494	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	291,552	0	7,383,733	0	7,383,733	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	234,434	0	234,434	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	1,672,325	0	1,672,325	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,822,201	0	84,035,852	0	84,035,852	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	20,136,935	0	20,136,935	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	1,994,770	0	1,994,770	194.01
194.02	07952	HWY 61 BUILDING	0	0	186,642	0	186,642	194.02
194.03	07953	MEDICAL BUILDING	0	0	1,118,145	0	1,118,145	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	347,575	0	347,575	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	0	1,375,178	0	1,375,178	194.05
194.06	07956	MENTAL HEALTH	0	0	7,882	0	7,882	194.06
200.00		Cross Foot Adjustments		0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,822,201	0	109,202,979	0	109,202,979	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 2:08 pm
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Cost Center Description	CAPITAL RELATED COSTS				Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00	2A			
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,443	0	563	2,006	2,006	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	84,092	576,076	1,718,606	2,378,774	366	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,454	0	708	2,162	12	6.00
7.00 00700	OPERATION OF PLANT	14,087	343,061	57,460	414,608	28	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,181	7,314	222	8,717	1	8.00
9.00 00900	HOUSEKEEPING	4,845	22,259	724	27,828	28	9.00
10.00 01000	DIETARY	8,965	85,038	9,525	103,528	34	10.00
11.00 01100	CAFETERIA	0	70,411	0	70,411	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,747	13,492	71,909	87,148	28	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	793	54,512	0	55,305	6	14.00
15.00 01500	PHARMACY	3,421	48,334	5,749	57,504	70	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,123	30,890	9,669	43,682	31	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	52,041	816,266	47,170	915,477	224	30.00
31.00 03100	INTENSIVE CARE UNIT	15,291	123,923	25,078	164,292	73	31.00
43.00 04300	NURSERY	1,776	0	8,978	10,754	15	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	189,311	163,649	244,400	597,360	47	50.00
51.00 05100	RECOVERY ROOM	7,027	166,079	972	174,078	40	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,113	0	3,264	4,377	37	52.00
53.00 05300	ANESTHESIOLOGY	1,840	2,726	7,321	11,887	2	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,537	234,060	165,651	403,248	52	54.00
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	231	8,722	47,341	56,294	5	56.00
57.00 05700	CT SCAN	323	17,625	9,424	27,372	9	57.00
58.00 05800	MRI	553	13,514	1,284	15,351	3	58.00
60.00 06000	LABORATORY	6,010	121,811	54,281	182,102	57	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	149	2,271	431	2,851	3	62.00
65.00 06500	RESPIRATORY THERAPY	17,086	26,802	6,977	50,865	33	65.00
66.00 06600	PHYSICAL THERAPY	52,497	87,310	15,092	154,899	39	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	257	0	243	500	6	68.00
69.00 06900	ELECTROCARDIOLOGY	15,109	209,234	288,314	512,657	39	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	531	4,543	2,126	7,200	7	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020	CANCER CENTER	4,433	0	200,906	205,339	33	76.00
76.01 03021	DIABETES CENTER	198	0	539	737	2	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	17,700	0	2,404	20,104	16	88.00
88.01 08801	RURAL HEALTH CLINIC II	3,048	0	56	3,104	12	88.01
88.02 08802	RURAL HEALTH CLINIC III	1,787	0	4,896	6,683	14	88.02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	19,437	634,290	233,501	887,228	105	91.00
91.01 09101	OUTPATIENT PSYCH	4,993	0	0	4,993	0	91.01
91.02 09102	WOUND CARE	0	0	0	0	5	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00 09900	CMHC	0	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	3,046	0	4,093	7,139	33	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW - SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	544,475	3,884,212	3,249,877	7,678,564	1,515	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	156,370	1,817	357,233	515,420	400	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	RENTAL	0	0	0	0	0	194.00
194.01 07951	CHILD DEVELOPMENT CENTER	1,666	0	7,609	9,275	31	194.01
194.02 07952	HWY 61 BUILDING	375	0	8,833	9,208	0	194.02
194.03 07953	MEDICAL BUILDING	1,589	0	0	1,589	26	194.03
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	1,044	0	0	1,044	7	194.04
194.05 07955	PHYSICIAN OFFICES MEXICO	56,243	0	24,459	80,702	27	194.05
194.06 07956	MENTAL HEALTH	0	5,860	0	5,860	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 260025

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
200.00	Cross Foot Adjustments			0		200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	761,762	3,648,011	8,301,662	2,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 2:08 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,379,140				5.00
6.00	00600	MAINTENANCE & REPAIRS	11,602	13,776			6.00
7.00	00700	OPERATION OF PLANT	78,959	1,215	494,810		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,009	16	640	18,383	8.00
9.00	00900	HOUSEKEEPING	29,329	49	1,946	0	59,180
10.00	01000	DIETARY	37,543	189	7,436	0	1,713
11.00	01100	CAFETERIA	2,063	156	6,157	0	1,419
13.00	01300	NURSING ADMINISTRATION	28,370	30	1,180	0	272
14.00	01400	CENTRAL SERVICES & SUPPLY	10,944	121	4,767	0	1,098
15.00	01500	PHARMACY	73,553	107	4,227	0	974
16.00	01600	MEDICAL RECORDS & LIBRARY	37,785	69	2,701	0	622
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	254,532	1,812	71,381	7,601	16,445
31.00	03100	INTENSIVE CARE UNIT	79,784	275	10,837	1,114	2,497
43.00	04300	NURSERY	16,496	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,244	363	14,311	3,046	3,297
51.00	05100	RECOVERY ROOM	42,614	369	14,523	1,311	3,346
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,405	0	0	0	0
53.00	05300	ANESTHESIOLOGY	22,821	6	238	0	55
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,417	587	23,120	1,190	4,716
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	8,274	19	763	0	176
57.00	05700	CT SCAN	18,970	39	1,541	0	355
58.00	05800	MRI	6,717	30	1,182	0	272
60.00	06000	LABORATORY	107,284	335	13,181	0	2,454
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	18,180	5	199	0	46
65.00	06500	RESPIRATORY THERAPY	36,350	126	4,950	0	540
66.00	06600	PHYSICAL THERAPY	48,163	276	10,877	83	1,759
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	2,864	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	62,181	464	18,297	425	4,216
70.00	07000	ELECTROENCEPHALOGRAPHY	6,348	10	397	96	92
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	198,199	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,668	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	77,822	0	0	0	0
76.00	03020	CANCER CENTER	53,899	897	35,355	322	0
76.01	03021	DIABETES CENTER	2,122	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	27,037	161	6,356	9	0
88.01	08801	RURAL HEALTH CLINIC II	18,860	378	14,885	0	0
88.02	08802	RURAL HEALTH CLINIC III	24,117	310	12,231	34	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	133,686	1,408	55,467	2,976	12,779
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0
91.02	09102	WOUND CARE	4,700	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	35,107	184	7,250	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,865,018	10,006	346,395	18,207	59,143
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	416,384	2,339	92,040	169	37
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	RENTAL	0	0	0	0	0
194.01	07951	CHILD DEVELOPMENT CENTER	36,178	798	31,422	0	0
194.02	07952	HWY 61 BUILDING	2,032	282	11,113	0	0
194.03	07953	MEDICAL BUILDING	24,360	0	0	0	0
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	6,926	89	3,512	7	0
194.05	07955	PHYSICIAN OFFICES MEXICO	28,070	262	10,328	0	0
194.06	07956	MENTAL HEALTH	172	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,379,140	13,776	494,810	18,383	59,180

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 2:08 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
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000	150,443				10.00
11.00	01100	105,591	185,797			11.00
13.00	01300	0	3,591	120,619		13.00
14.00	01400	0	1,334	0	73,575	14.00
15.00	01500	0	6,897	0	0	15.00
16.00	01600	0	6,472	0	0	16.00
19.00	01900	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	39,153	37,082	81,774	0	30.00
31.00	03100	5,699	10,174	22,490	0	31.00
43.00	04300	0	2,296	5,078	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	7,168	0	0	50.00
51.00	05100	0	5,552	0	0	51.00
52.00	05200	0	4,525	10,004	0	52.00
53.00	05300	0	3,334	0	0	53.00
54.00	05400	0	6,939	0	0	54.00
56.00	03450	0	578	0	0	56.00
57.00	05700	0	1,245	0	0	57.00
58.00	05800	0	414	0	0	58.00
60.00	06000	0	11,422	0	0	60.00
62.00	06200	0	485	0	0	62.00
65.00	06500	0	5,021	0	0	65.00
66.00	06600	0	4,400	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	824	0	0	68.00
69.00	06900	0	4,992	0	0	69.00
70.00	07000	0	1,023	0	0	70.00
71.00	07100	0	0	0	64,734	71.00
72.00	07200	0	0	0	8,841	72.00
73.00	07300	0	0	0	0	73.00
76.00	03020	0	2,578	0	0	76.00
76.01	03021	0	285	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
88.01	08801	0	0	0	0	88.01
88.02	08802	0	0	0	0	88.02
89.00	08900	0	0	0	0	89.00
91.00	09100	0	16,286	0	0	91.00
91.01	09101	0	0	0	0	91.01
91.02	09102	0	574	1,273	0	91.02
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	0	0	0	0	99.00
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
114.00	11400					114.00
118.00		150,443	145,491	120,619	73,575	143,332
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	31,366	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	8,940	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
200.00						200.00
201.00		0	0	0	0	201.00
202.00		150,443	185,797	120,619	73,575	143,332

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 2:08 pm
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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
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91,362				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	60,297	1,485,778	0	1,485,778	30.00
31.00	03100	INTENSIVE CARE UNIT	11,878	309,113	0	309,113	31.00
43.00	04300	NURSERY	4,569	39,208	0	39,208	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	702,836	0	702,836	50.00
51.00	05100	RECOVERY ROOM	0	241,833	0	241,833	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,348	0	55,348	52.00
53.00	05300	ANESTHESIOLOGY	0	38,343	0	38,343	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	528,269	0	528,269	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	66,109	0	66,109	56.00
57.00	05700	CT SCAN	0	49,531	0	49,531	57.00
58.00	05800	MRI	0	23,969	0	23,969	58.00
60.00	06000	LABORATORY	0	316,835	0	316,835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	21,769	0	21,769	62.00
65.00	06500	RESPIRATORY THERAPY	0	97,885	0	97,885	65.00
66.00	06600	PHYSICAL THERAPY	0	220,496	0	220,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,194	0	4,194	68.00
69.00	06900	ELECTROCARDIOLOGY	0	603,271	0	603,271	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,173	0	15,173	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	262,933	0	262,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,509	0	45,509	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	221,154	0	221,154	73.00
76.00	03020	CANCER CENTER	0	298,423	0	298,423	76.00
76.01	03021	DIABETES CENTER	0	3,146	0	3,146	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	53,683	0	53,683	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	37,239	0	37,239	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	43,389	0	43,389	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	14,618	1,124,553	0	1,124,553	91.00
91.01	09101	OUTPATIENT PSYCH	0	4,993	0	4,993	91.01
91.02	09102	WOUND CARE	0	6,552	0	6,552	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	49,713	0	49,713	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,362	0	6,971,247	0	6,971,247
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,058,155	0	1,058,155	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	86,644	0	86,644	194.01
194.02	07952	HWY 61 BUILDING	0	22,635	0	22,635	194.02
194.03	07953	MEDICAL BUILDING	0	25,975	0	25,975	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	11,585	0	11,585	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	119,389	0	119,389	194.05
194.06	07956	MENTAL HEALTH	0	6,032	0	6,032	194.06
200.00		Cross Foot Adjustments		0	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 260025

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	91,362	0	8,301,662	0	8,301,662	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet B-1 Date/Time Prepared: 2/27/2014 2:08 pm
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	171,349				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,427,365			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	529	44,651,006		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	25,363	1,614,657	8,123,515	-28,011,578	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	665	264,246	0	6.00
7.00 00700	OPERATION OF PLANT	15,104	53,985	626,611	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	322	209	30,701	0	8.00
9.00 00900	HOUSEKEEPING	980	680	614,737	0	9.00
10.00 01000	DIETARY	3,744	8,949	765,482	0	10.00
11.00 01100	CAFETERIA	3,100	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	594	67,560	616,902	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,400	0	126,171	0	14.00
15.00 01500	PHARMACY	2,128	5,401	1,549,797	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,360	9,084	681,034	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	35,938	44,317	4,984,683	0	30.00
31.00 03100	INTENSIVE CARE UNIT	5,456	23,561	1,612,706	0	31.00
43.00 04300	NURSERY	0	8,435	325,329	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,205	229,618	1,036,044	0	50.00
51.00 05100	RECOVERY ROOM	7,312	913	884,323	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	3,067	821,152	0	52.00
53.00 05300	ANESTHESIOLOGY	120	6,878	36,797	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,305	155,632	1,160,185	0	54.00
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	384	44,478	110,245	0	56.00
57.00 05700	CT SCAN	776	8,854	209,462	0	57.00
58.00 05800	MRI	595	1,206	66,108	0	58.00
60.00 06000	LABORATORY	5,363	50,998	1,270,646	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	405	73,856	0	62.00
65.00 06500	RESPIRATORY THERAPY	1,180	6,555	742,264	0	65.00
66.00 06600	PHYSICAL THERAPY	3,844	14,179	861,070	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	228	138,364	0	68.00
69.00 06900	ELECTROCARDIOLOGY	9,212	270,876	873,184	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	200	1,997	152,097	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CANCER CENTER	0	188,754	736,836	0	76.00
76.01 03021	DIABETES CENTER	0	506	38,655	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	2,259	357,911	0	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	53	263,907	0	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	4,600	308,048	0	88.02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	27,926	219,378	2,324,393	0	91.00
91.01 09101	OUTPATIENT PSYCH	0	0	0	0	91.01
91.02 09102	WOUND CARE	0	0	113,809	0	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	0	3,845	738,401	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	171,011	3,053,311	33,639,671	-28,011,578	63,645,959
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	80	335,626	8,968,768	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	RENTAL	0	0	0	0	194.00
194.01 07951	CHILD DEVELOPMENT CENTER	0	7,149	690,443	0	194.01
194.02 07952	HWY 61 BUILDING	0	8,299	3,898	0	194.02
194.03 07953	MEDICAL BUILDING	0	0	585,795	0	194.03
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	0	0	163,412	0	194.04
194.05 07955	PHYSICIAN OFFICES MEXICO	0	22,980	599,019	0	194.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00					4.00
194.06	07956	MENTAL HEALTH	258	0	0	0	5,860	194.06
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)	3,891,889	3,648,011	12,154,020		28,011,578	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.713229	1.064378	0.272200		0.345007	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,006		2,379,140	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000045		0.029303	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet B-1	
Date/Time Prepared: 2/27/2014 2:08 pm							
Cost Center	Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	273,226					6.00
7.00	00700	24,104	249,122				7.00
8.00	00800	322	322	476,735			8.00
9.00	00900	980	980	0	129,322		9.00
10.00	01000	3,744	3,744	0	3,744	244,244	10.00
11.00	01100	3,100	3,100	0	3,100	171,426	11.00
13.00	01300	594	594	0	594	0	13.00
14.00	01400	2,400	2,400	0	2,400	0	14.00
15.00	01500	2,128	2,128	0	2,128	0	15.00
16.00	01600	1,360	1,360	0	1,360	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	35,938	35,938	197,099	35,938	63,565	30.00
31.00	03100	5,456	5,456	28,883	5,456	9,253	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,205	7,205	79,000	7,205	0	50.00
51.00	05100	7,312	7,312	34,011	7,312	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	120	120	0	120	0	53.00
54.00	05400	11,640	11,640	30,865	10,305	0	54.00
56.00	03450	384	384	0	384	0	56.00
57.00	05700	776	776	0	776	0	57.00
58.00	05800	595	595	0	595	0	58.00
60.00	06000	6,636	6,636	0	5,363	0	60.00
62.00	06200	100	100	0	100	0	62.00
65.00	06500	2,492	2,492	0	1,180	0	65.00
66.00	06600	5,476	5,476	2,164	3,844	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	9,212	9,212	11,014	9,212	0	69.00
70.00	07000	200	200	2,487	200	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	17,800	17,800	8,346	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,200	3,200	235	0	0	88.00
88.01	08801	7,494	7,494	0	0	0	88.01
88.02	08802	6,158	6,158	877	0	0	88.02
89.00	08900	0	0	0	0	0	89.00
91.00	09100	27,926	27,926	77,190	27,926	0	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	0	0	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	3,650	3,650	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		198,502	174,398	472,171	129,242	244,244	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	46,341	46,341	4,391	80	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	15,820	15,820	0	0	0	194.01
194.02	07952	5,595	5,595	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	1,768	1,768	173	0	0	194.04
194.05	07955	5,200	5,200	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	532,518	3,671,186	418,887	1,362,544	1,825,145	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.949002	14.736499	0.878658	10.536057	7.472630	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,776	494,810	18,383	59,180	150,443	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.050420	1.986216	0.038560	0.457617	0.615954	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	52,103					11.00
13.00	01300	1,007	318,219				13.00
14.00	01400	374	0	8,482,133			14.00
15.00	01500	1,934	0	0	100		15.00
16.00	01600	1,815	0	0	0	34,375	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,399	215,736	0	0	22,687	30.00
31.00	03100	2,853	59,334	0	0	4,469	31.00
43.00	04300	644	13,397	0	0	1,719	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,010	0	0	0	0	50.00
51.00	05100	1,557	0	0	0	0	51.00
52.00	05200	1,269	26,393	0	0	0	52.00
53.00	05300	935	0	0	0	0	53.00
54.00	05400	1,946	0	0	0	0	54.00
56.00	03450	162	0	0	0	0	56.00
57.00	05700	349	0	0	0	0	57.00
58.00	05800	116	0	0	0	0	58.00
60.00	06000	3,203	0	0	0	0	60.00
62.00	06200	136	0	0	0	0	62.00
65.00	06500	1,408	0	0	0	0	65.00
66.00	06600	1,234	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	231	0	0	0	0	68.00
69.00	06900	1,400	0	0	0	0	69.00
70.00	07000	287	0	0	0	0	70.00
71.00	07100	0	0	7,462,839	0	0	71.00
72.00	07200	0	0	1,019,294	0	0	72.00
73.00	07300	0	0	0	100	0	73.00
76.00	03020	723	0	0	0	0	76.00
76.01	03021	80	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
88.02	08802	0	0	0	0	0	88.02
89.00	08900	0	0	0	0	0	89.00
91.00	09100	4,567	0	0	0	5,500	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	161	3,359	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		40,800	318,219	8,482,133	100	34,375	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	8,796	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	2,507	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,460,093	1,346,575	578,145	3,488,217	1,822,201	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	28.023204	4.231598	0.068160	34,882.170000	53.009484	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	185,797	120,619	73,575	143,332	91,362	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.565956	0.379044	0.008674	1,433.320000	2.657804	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
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
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	CANCER CENTER	76.00
76.01	03021	DIABETES CENTER	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
91.00	09100	EMERGENCY	91.00
91.01	09101	OUTPATIENT PSYCH	91.01
91.02	09102	WOUND CARE	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	FAMILY PRACTICE	93.00
OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	99.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW - SNF	114.00
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
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	RENTAL	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	194.01
194.02	07952	HWY 61 BUILDING	194.02
194.03	07953	MEDICAL BUILDING	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	194.05
194.06	07956	MENTAL HEALTH	194.06
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		15,716,446	0	15,716,446	30.00
31.00	03100 INTENSIVE CARE UNIT		4,473,031	0	4,473,031	31.00
43.00	04300 NURSERY		923,011	0	923,011	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,867,353	24,574	3,891,927	50.00
51.00	05100 RECOVERY ROOM		2,228,532	0	2,228,532	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,818,215	0	1,818,215	52.00
53.00	05300 ANESTHESIOLOGY		1,076,953	5,039	1,081,992	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,442,781	0	4,442,781	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC		394,783	0	394,783	56.00
57.00	05700 CT SCAN		901,631	0	901,631	57.00
58.00	05800 MRI		327,753	0	327,753	58.00
60.00	06000 LABORATORY		5,181,302	349,500	5,530,802	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		841,006	0	841,006	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,761,951	0	1,761,951	65.00
66.00	06600 PHYSICAL THERAPY	0	2,379,015	0	2,379,015	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	137,947	0	137,947	68.00
69.00	06900 ELECTROCARDIOLOGY		3,153,777	0	3,153,777	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		307,029	0	307,029	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		9,606,000	0	9,606,000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,752,555	0	1,752,555	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,060,227	0	7,060,227	73.00
76.00	03020 CANCER CENTER		2,798,582	33,034	2,831,616	76.00
76.01	03021 DIABETES CENTER		99,664	0	99,664	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		1,294,591	0	1,294,591	88.00
88.01	08801 RURAL HEALTH CLINIC II		990,731	0	990,731	88.01
88.02	08802 RURAL HEALTH CLINIC III		1,210,494	0	1,210,494	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		7,383,733	58,042	7,441,775	91.00
91.01	09101 OUTPATIENT PSYCH		0	0	0	91.01
91.02	09102 WOUND CARE		234,434	0	234,434	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		743,697	0	743,697	92.00
93.00	04040 FAMILY PRACTICE		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC		0	0	0	99.00
101.00	10100 HOME HEALTH AGENCY		1,672,325	0	1,672,325	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW - SNF					114.00
200.00	Subtotal (see instructions)	0	84,779,549	470,189	85,249,738	200.00
201.00	Less Observation Beds		743,697		743,697	201.00
202.00	Total (see instructions)	0	84,035,852	470,189	84,506,041	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVII I			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,962,282		5,962,282		30.00
31.00	03100	INTENSIVE CARE UNIT	1,771,116		1,771,116		31.00
43.00	04300	NURSERY	354,661		354,661		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,345,447	9,447,741	19,793,188	0.195388	50.00
51.00	05100	RECOVERY ROOM	1,447,224	2,379,524	3,826,748	0.582357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	763,632	148,754	912,386	1.992813	52.00
53.00	05300	ANESTHESIOLOGY	2,961,734	2,020,541	4,982,275	0.216157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,664,436	5,738,979	8,403,415	0.528688	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	702,999	1,920,113	2,623,112	0.150502	56.00
57.00	05700	CT SCAN	3,637,587	9,215,953	12,853,540	0.070147	57.00
58.00	05800	MRI	596,633	3,484,706	4,081,339	0.080305	58.00
60.00	06000	LABORATORY	12,023,209	20,555,435	32,578,644	0.159040	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	669,175	463,765	1,132,940	0.742322	62.00
65.00	06500	RESPIRATORY THERAPY	941,654	150,123	1,091,777	1.613838	65.00
66.00	06600	PHYSICAL THERAPY	940,243	1,351,002	2,291,245	1.038307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	47,807	59,035	106,842	1.291131	68.00
69.00	06900	ELECTROCARDIOLOGY	4,625,488	7,570,183	12,195,671	0.258598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,828	660,221	688,049	0.446231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,499,392	28,448,974	82,948,366	0.115807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	289,978	2,496,809	2,786,787	0.628880	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,305,847	17,904,595	46,210,442	0.152784	73.00
76.00	03020	CANCER CENTER	45,875	5,403,559	5,449,434	0.513555	76.00
76.01	03021	DIABETES CENTER	0	9,248	9,248	10.776817	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	823,542	823,542		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	738,082	738,082		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,151,348	1,151,348		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	637,264	2,053,774	2,691,038	2.743823	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	91.01
91.02	09102	WOUND CARE	0	41,962	41,962	5.586817	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,910	392,610	488,520	1.522347	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	927,826	927,826		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (see instructions)	134,357,421	125,558,404	259,915,825		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	134,357,421	125,558,404	259,915,825		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 2:08 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.196630		50.00
51.00	05100 RECOVERY ROOM	0.582357		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.992813		52.00
53.00	05300 ANESTHESIOLOGY	0.217168		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.528688		54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.150502		56.00
57.00	05700 CT SCAN	0.070147		57.00
58.00	05800 MRI	0.080305		58.00
60.00	06000 LABORATORY	0.169768		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.742322		62.00
65.00	06500 RESPIRATORY THERAPY	1.613838		65.00
66.00	06600 PHYSICAL THERAPY	1.038307		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	1.291131		68.00
69.00	06900 ELECTROCARDIOLOGY	0.258598		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.446231		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.115807		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.628880		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152784		73.00
76.00	03020 CANCER CENTER	0.519617		76.00
76.01	03021 DIABETES CENTER	10.776817		76.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
88.02	08802 RURAL HEALTH CLINIC III			88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	2.765392		91.00
91.01	09101 OUTPATIENT PSYCH	0.000000		91.01
91.02	09102 WOUND CARE	5.586817		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.522347		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
99.00	09900 CMHC			99.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW - SNF			114.00
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: 260025

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

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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	15,716,446		15,716,446	0	15,716,446	30.00
31.00	03100 INTENSIVE CARE UNIT	4,473,031		4,473,031	0	4,473,031	31.00
43.00	04300 NURSERY	923,011		923,011	0	923,011	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,867,353		3,867,353	24,574	3,891,927	50.00
51.00	05100 RECOVERY ROOM	2,228,532		2,228,532	0	2,228,532	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,818,215		1,818,215	0	1,818,215	52.00
53.00	05300 ANESTHESIOLOGY	1,076,953		1,076,953	5,039	1,081,992	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,442,781		4,442,781	0	4,442,781	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	394,783		394,783	0	394,783	56.00
57.00	05700 CT SCAN	901,631		901,631	0	901,631	57.00
58.00	05800 MRI	327,753		327,753	0	327,753	58.00
60.00	06000 LABORATORY	5,181,302		5,181,302	349,500	5,530,802	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	841,006		841,006	0	841,006	62.00
65.00	06500 RESPIRATORY THERAPY	1,761,951	0	1,761,951	0	1,761,951	65.00
66.00	06600 PHYSICAL THERAPY	2,379,015	0	2,379,015	0	2,379,015	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	137,947	0	137,947	0	137,947	68.00
69.00	06900 ELECTROCARDIOLOGY	3,153,777		3,153,777	0	3,153,777	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	307,029		307,029	0	307,029	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,606,000		9,606,000	0	9,606,000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,752,555		1,752,555	0	1,752,555	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,060,227		7,060,227	0	7,060,227	73.00
76.00	03020 CANCER CENTER	2,798,582		2,798,582	33,034	2,831,616	76.00
76.01	03021 DIABETES CENTER	99,664		99,664	0	99,664	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,294,591		1,294,591	0	1,294,591	88.00
88.01	08801 RURAL HEALTH CLINIC II	990,731		990,731	0	990,731	88.01
88.02	08802 RURAL HEALTH CLINIC III	1,210,494		1,210,494	0	1,210,494	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100 EMERGENCY	7,383,733		7,383,733	58,042	7,441,775	91.00
91.01	09101 OUTPATIENT PSYCH	0		0	0	0	91.01
91.02	09102 WOUND CARE	234,434		234,434	0	234,434	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	743,697		743,697	0	743,697	92.00
93.00	04040 FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0		0	0	0	99.00
101.00	10100 HOME HEALTH AGENCY	1,672,325		1,672,325	0	1,672,325	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW - SNF						114.00
200.00	Subtotal (see instructions)	84,779,549	0	84,779,549	470,189	85,249,738	200.00
201.00	Less Observation Beds	743,697		743,697		743,697	201.00
202.00	Total (see instructions)	84,035,852	0	84,035,852	470,189	84,506,041	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

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

Worksheet C
Part I
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		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	5,962,282		5,962,282		30.00
31.00	03100	INTENSIVE CARE UNIT	1,771,116		1,771,116		31.00
43.00	04300	NURSERY	354,661		354,661		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,345,447	9,447,741	19,793,188	0.195388	50.00
51.00	05100	RECOVERY ROOM	1,447,224	2,379,524	3,826,748	0.582357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	763,632	148,754	912,386	1.992813	52.00
53.00	05300	ANESTHESIOLOGY	2,961,734	2,020,541	4,982,275	0.216157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,664,436	5,738,979	8,403,415	0.528688	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	702,999	1,920,113	2,623,112	0.150502	56.00
57.00	05700	CT SCAN	3,637,587	9,215,953	12,853,540	0.070147	57.00
58.00	05800	MRI	596,633	3,484,706	4,081,339	0.080305	58.00
60.00	06000	LABORATORY	12,023,209	20,555,435	32,578,644	0.159040	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	669,175	463,765	1,132,940	0.742322	62.00
65.00	06500	RESPIRATORY THERAPY	941,654	150,123	1,091,777	1.613838	65.00
66.00	06600	PHYSICAL THERAPY	940,243	1,351,002	2,291,245	1.038307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	47,807	59,035	106,842	1.291131	68.00
69.00	06900	ELECTROCARDIOLOGY	4,625,488	7,570,183	12,195,671	0.258598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,828	660,221	688,049	0.446231	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,499,392	28,448,974	82,948,366	0.115807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	289,978	2,496,809	2,786,787	0.628880	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,305,847	17,904,595	46,210,442	0.152784	73.00
76.00	03020	CANCER CENTER	45,875	5,403,559	5,449,434	0.513555	76.00
76.01	03021	DIABETES CENTER	0	9,248	9,248	10.776817	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	823,542	823,542	1.571979	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	738,082	738,082	1.342305	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,151,348	1,151,348	1.051371	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	637,264	2,053,774	2,691,038	2.743823	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	91.01
91.02	09102	WOUND CARE	0	41,962	41,962	5.586817	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	95,910	392,610	488,520	1.522347	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	927,826	927,826		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (see instructions)	134,357,421	125,558,404	259,915,825		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	134,357,421	125,558,404	259,915,825		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

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

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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
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
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
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 CANCER CENTER	0.000000			76.00
76.01	03021 DIABETES CENTER	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
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	09100 EMERGENCY	0.000000			91.00
91.01	09101 OUTPATIENT PSYCH	0.000000			91.01
91.02	09102 WOUND CARE	0.000000			91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW - SNF				114.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part I Date/Time Prepared: 2/27/2014 2:08 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,485,778	0	1,485,778	14,962	99.30	30.00
31.00	INTENSIVE CARE UNIT	309,113		309,113	2,075	148.97	31.00
43.00	NURSERY	39,208		39,208	1,375	28.51	43.00
200.00	Total (Lines 30-199)	1,834,099		1,834,099	18,412		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,179	911,475				
31.00	INTENSIVE CARE UNIT	1,306	194,555				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	10,485	1,106,030				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/27/2014 2:08 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	702,836	19,793,188	0.035509	6,044,337	214,628	50.00
51.00	05100 RECOVERY ROOM	241,833	3,826,748	0.063195	793,061	50,117	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,348	912,386	0.060663	4,661	283	52.00
53.00	05300 ANESTHESIOLOGY	38,343	4,982,275	0.007696	1,570,222	12,084	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	528,269	8,403,415	0.062864	1,719,853	108,117	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	66,109	2,623,112	0.025203	486,881	12,271	56.00
57.00	05700 CT SCAN	49,531	12,853,540	0.003853	2,184,503	8,417	57.00
58.00	05800 MRI	23,969	4,081,339	0.005873	389,854	2,290	58.00
60.00	06000 LABORATORY	316,835	32,578,644	0.009725	7,952,826	77,341	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	21,769	1,132,940	0.019215	432,962	8,319	62.00
65.00	06500 RESPIRATORY THERAPY	97,885	1,091,777	0.089657	574,957	51,549	65.00
66.00	06600 PHYSICAL THERAPY	220,496	2,291,245	0.096234	722,744	69,553	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	4,194	106,842	0.039254	38,863	1,526	68.00
69.00	06900 ELECTROCARDIOLOGY	603,271	12,195,671	0.049466	2,469,680	122,165	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,173	688,049	0.022052	15,062	332	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	262,933	82,948,366	0.003170	30,074,016	95,335	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	45,509	2,786,787	0.016330	198,784	3,246	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	221,154	46,210,442	0.004786	14,844,164	71,044	73.00
76.00	03020 CANCER CENTER	298,423	5,449,434	0.054762	32,118	1,759	76.00
76.01	03021 DIABETES CENTER	3,146	9,248	0.340182	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	53,683	823,542	0.065186	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	37,239	738,082	0.050454	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	43,389	1,151,348	0.037685	0	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	1,124,553	2,691,038	0.417888	367,363	153,517	91.00
91.01	09101 OUTPATIENT PSYCH	4,993	0	0.000000	0	0	91.01
91.02	09102 WOUND CARE	6,552	41,962	0.156141	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	70,307	488,520	0.143918	67,620	9,732	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	5,157,742	250,899,940		70,984,531	1,073,625	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/27/2014 2:08 pm	
Title XVIII			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
43.00	04300	NURSERY	0	0	0	0	0 43.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,962	0.00	9,179	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,075	0.00	1,306	0	31.00	
43.00	04300	NURSERY	1,375	0.00	0	0	43.00	
200.00		Total (lines 30-199)	18,412		10,485	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	CANCER CENTER	0	0	0	0	0	0	76.00
76.01	03021	DIABETES CENTER	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
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 2:08 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	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	19,793,188	0.000000	0.000000	6,044,337	50.00
51.00	05100 RECOVERY ROOM	0	3,826,748	0.000000	0.000000	793,061	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	912,386	0.000000	0.000000	4,661	52.00
53.00	05300 ANESTHESIOLOGY	0	4,982,275	0.000000	0.000000	1,570,222	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,403,415	0.000000	0.000000	1,719,853	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2,623,112	0.000000	0.000000	486,881	56.00
57.00	05700 CT SCAN	0	12,853,540	0.000000	0.000000	2,184,503	57.00
58.00	05800 MRI	0	4,081,339	0.000000	0.000000	389,854	58.00
60.00	06000 LABORATORY	0	32,578,644	0.000000	0.000000	7,952,826	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,132,940	0.000000	0.000000	432,962	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,091,777	0.000000	0.000000	574,957	65.00
66.00	06600 PHYSICAL THERAPY	0	2,291,245	0.000000	0.000000	722,744	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	106,842	0.000000	0.000000	38,863	68.00
69.00	06900 ELECTROCARDIOLOGY	0	12,195,671	0.000000	0.000000	2,469,680	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	688,049	0.000000	0.000000	15,062	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	82,948,366	0.000000	0.000000	30,074,016	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,786,787	0.000000	0.000000	198,784	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	46,210,442	0.000000	0.000000	14,844,164	73.00
76.00	03020 CANCER CENTER	0	5,449,434	0.000000	0.000000	32,118	76.00
76.01	03021 DIABETES CENTER	0	9,248	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	823,542	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	738,082	0.000000	0.000000	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	1,151,348	0.000000	0.000000	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	2,691,038	0.000000	0.000000	367,363	91.00
91.01	09101 OUTPATIENT PSYCH	0	0	0.000000	0.000000	0	91.01
91.02	09102 WOUND CARE	0	41,962	0.000000	0.000000	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	488,520	0.000000	0.000000	67,620	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	250,899,940			70,984,531	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 2:08 pm
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Cost Center Description	Title XVIII					Hospital	PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		
	11.00	12.00	12.01	13.00	13.01		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	864,178	2,592,535	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	244,073	732,218	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	408	1,225	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	149,558	448,673	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	419,598	1,258,793	0	0	0	54.00
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	233,706	701,117	0	0	0	56.00
57.00 05700 CT SCAN	0	712,777	2,138,332	0	0	0	57.00
58.00 05800 MRI	0	307,386	922,159	0	0	0	58.00
60.00 06000 LABORATORY	0	301,238	903,714	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	28,009	84,028	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	11,772	35,317	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	985,461	2,956,383	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	56,184	168,551	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,424,920	7,274,759	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	389,734	1,169,201	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,442,392	4,327,176	0	0	0	73.00
76.00 03020 CANCER CENTER	0	653,074	1,959,221	0	0	0	76.00
76.01 03021 DIABETES CENTER	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
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00 09100 EMERGENCY	0	131,199	393,598	0	0	0	91.00
91.01 09101 OUTPATIENT PSYCH	0	0	0	0	0	0	91.01
91.02 09102 WOUND CARE	0	5,745	17,234	0	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	48,645	145,935	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	9,410,057	28,230,169	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed 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	0.195388	864,178	2,592,535	0	0	50.00
51.00 05100 RECOVERY ROOM	0.582357	244,073	732,218	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.992813	408	1,225	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.216157	149,558	448,673	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.528688	419,598	1,258,793	0	0	54.00
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.150502	233,706	701,117	0	0	56.00
57.00 05700 CT SCAN	0.070147	712,777	2,138,332	0	0	57.00
58.00 05800 MRI	0.080305	307,386	922,159	0	0	58.00
60.00 06000 LABORATORY	0.159040	301,238	903,714	5,152	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.742322	28,009	84,028	60	0	62.00
65.00 06500 RESPIRATORY THERAPY	1.613838	11,772	35,317	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1.038307	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.291131	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.258598	985,461	2,956,383	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.446231	56,184	168,551	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.115807	2,424,920	7,274,759	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.628880	389,734	1,169,201	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.152784	1,442,392	4,327,176	0	28,416	73.00
76.00 03020 CANCER CENTER	0.513555	653,074	1,959,221	0	0	76.00
76.01 03021 DIABETES CENTER	10.776817	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
88.02 08802 RURAL HEALTH CLINIC III	0.000000					88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 09100 EMERGENCY	2.743823	131,199	393,598	0	0	91.00
91.01 09101 OUTPATIENT PSYCH	0.000000	0	0	0	0	91.01
91.02 09102 WOUND CARE	5.586817	5,745	17,234	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.522347	48,645	145,935	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00 Subtotal (see instructions)		9,410,057	28,230,169	5,212	28,416	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		9,410,057	28,230,169	5,212	28,416	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Hospital	PPS

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	168,850	506,550	0	0	50.00
51.00	05100 RECOVERY ROOM	142,138	426,412	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	813	2,441	0	0	52.00
53.00	05300 ANESTHESIOLOGY	32,328	96,984	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	221,836	665,509	0	0	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	35,173	105,520	0	0	56.00
57.00	05700 CT SCAN	49,999	149,998	0	0	57.00
58.00	05800 MRI	24,685	74,054	0	0	58.00
60.00	06000 LABORATORY	47,909	143,727	819	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	20,792	62,376	45	0	62.00
65.00	06500 RESPIRATORY THERAPY	18,998	56,996	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	254,838	764,515	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	25,071	75,213	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	280,823	842,468	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	245,096	735,287	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	220,374	661,123	0	4,342	73.00
76.00	03020 CANCER CENTER	335,389	1,006,168	0	0	76.00
76.01	03021 DIABETES CENTER	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
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100 EMERGENCY	359,987	1,079,963	0	0	91.00
91.01	09101 OUTPATIENT PSYCH	0	0	0	0	91.01
91.02	09102 WOUND CARE	32,096	96,283	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	74,055	222,164	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	93.00
200.00	Subtotal (see instructions)	2,591,250	7,773,751	864	4,342	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,591,250	7,773,751	864	4,342	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/27/2014 2:08 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,962	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,962	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,254	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9,179	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		15,716,446	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		15,716,446	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		15,716,446	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)		1,050.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,641,805	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,641,805	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1		
		Title XVIII		Hospital		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	4,473,031	2,075	2,155.68	1,306	2,815,318	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)	14,224,398						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,681,521						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)	1,106,030						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,073,625						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,179,655						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,501,866						53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges	0						54.00
55.00	Target amount per discharge	0.00						55.00
56.00	Target amount (line 54 x line 55)	0						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0						57.00
58.00	Bonus payment (see instructions)	0						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0						61.00
62.00	Relief payment (see instructions)	0						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)	708						87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,050.42						88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	743,697						89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 2:08 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	1,485,778	15,716,446	0.094537	743,697	70,307	90.00
91.00	Nursing School cost	0	15,716,446	0.000000	743,697	0	91.00
92.00	Allied health cost	0	15,716,446	0.000000	743,697	0	92.00
93.00	All other Medical Education	0	15,716,446	0.000000	743,697	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/27/2014 2:08 pm
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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		3,978,389		30.00
31.00	03100 INTENSIVE CARE UNIT		1,158,182		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.196630	6,044,337	1,188,498	50.00
51.00	05100 RECOVERY ROOM	0.582357	793,061	461,845	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.992813	4,661	9,289	52.00
53.00	05300 ANESTHESIOLOGY	0.217168	1,570,222	341,002	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.528688	1,719,853	909,266	54.00
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.150502	486,881	73,277	56.00
57.00	05700 CT SCAN	0.070147	2,184,503	153,236	57.00
58.00	05800 MRI	0.080305	389,854	31,307	58.00
60.00	06000 LABORATORY	0.169768	7,952,826	1,350,135	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.742322	432,962	321,397	62.00
65.00	06500 RESPIRATORY THERAPY	1.613838	574,957	927,887	65.00
66.00	06600 PHYSICAL THERAPY	1.038307	722,744	750,430	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.291131	38,863	50,177	68.00
69.00	06900 ELECTROCARDIOLOGY	0.258598	2,469,680	638,654	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.446231	15,062	6,721	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.115807	30,074,016	3,482,782	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.628880	198,784	125,011	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.152784	14,844,164	2,267,951	73.00
76.00	03020 CANCER CENTER	0.519617	32,118	16,689	76.00
76.01	03021 DIABETES CENTER	10.776817	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
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	2.765392	367,363	1,015,903	91.00
91.01	09101 OUTPATIENT PSYCH	0.000000	0	0	91.01
91.02	09102 WOUND CARE	5.586817	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.522347	67,620	102,941	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		70,984,531	14,224,398	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		70,984,531		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 2:08 pm	
		Title XVII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		16,965,126		1.00
2.00	Outlier payments for discharges. (see instructions)		522,007		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		89.06		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.85		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.01		31.00
32.00	Sum of lines 30 and 31		22.86		32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.07		33.00
34.00	Disproportionate share adjustment (see instructions)		1,369,086		34.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 2:08 pm	
		Title XVII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		18,856,219		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		22,998,912		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		22,998,912		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,403,854		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,402,766		59.00
60.00	Primary payer payments		3,911		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,398,855		61.00
62.00	Deductibles billed to program beneficiaries		2,143,920		62.00
63.00	Coinurance billed to program beneficiaries		13,828		63.00
64.00	Allowable bad debts (see instructions)		645,406		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		419,514		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		542,893		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,660,621		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-156		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-1,640		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,658,825		71.00
71.01	Sequestration adjustment (see instructions)		226,588		71.01
72.00	Interim payments		22,688,175		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-255,938		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		1,261,544		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 2:08 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/27/2014 2:08 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
			1.00	1.01	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		5,206		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,591,250	7,773,751	2.00
3.00	PPS payments		1,753,804	5,261,413	3.00
4.00	Outlier payment (see instructions)		102,392	307,176	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.882	0.882	5.00
6.00	Line 2 times line 5		2,285,483	6,856,448	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		81.22	81.22	7.00
8.00	Transitional corridor payment (see instructions)		364,894	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)		5,206		11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		33,628		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)		33,628		14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0		16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000		17.00
18.00	Total customary charges (see instructions)		33,628		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,422		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)		5,206		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)		7,789,679		24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance (for CAH, see instructions)		0		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,585,772		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)		6,209,113		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)		6,209,113		30.00
31.00	Primary payer payments		1,481		31.00
32.00	Subtotal (line 30 minus line 31)		6,207,632		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)		189,569		34.00
35.00	Adjusted reimbursable bad debts (see instructions)		123,220		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		101,579		36.00
37.00	Subtotal (see instructions)		6,330,852		37.00
38.00	MSP-LCC reconciliation amount from PS&R		749		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)		6,330,103		40.00
40.01	Sequestration adjustment (see instructions)		63,301		40.01
41.00	Interim payments		6,406,267		41.00
42.00	Tentative settlement (for contractors use only)		0		42.00
43.00	Balance due provider/program (see instructions)		-139,465		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: 260025

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,688,175		6,406,267	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)		22,688,175		6,406,267	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		255,938		139,465	6.02
7.00	Total Medicare program liability (see instructions)		22,432,237		6,266,802	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: 260025

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

Worksheet E-1
Part II
Date/Time Prepared:
2/27/2014 2:08 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			4,476 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			10,485 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6 line 2			626 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			16,329 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			259,915,825 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			7,028,972 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,864,181 8.00
9.00	Sequestration adjustment amount (see instructions)			37,284 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,826,897 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,796,884 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)			30,013 32.00

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

Provider CCN: 260025

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

Worksheet G

Date/Time Prepared:
2/27/2014 2:08 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	16,806,251	0	0	0	1.00
2.00	Temporary investments	1,466,409	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,241,261	0	0	0	4.00
5.00	Other receivable	1,483,198	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,507,309	0	0	0	7.00
8.00	Prepaid expenses	672,870	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	36,177,298	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,693,370	0	0	0	12.00
13.00	Land improvements	7,112,763	0	0	0	13.00
14.00	Accumulated depreciation	-4,912,606	0	0	0	14.00
15.00	Buildings	42,883,675	0	0	0	15.00
16.00	Accumulated depreciation	-24,855,216	0	0	0	16.00
17.00	Leasehold improvements	18,479,557	0	0	0	17.00
18.00	Accumulated depreciation	-8,212,625	0	0	0	18.00
19.00	Fixed equipment	124,221	0	0	0	19.00
20.00	Accumulated depreciation	-98,004	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	61,863,650	0	0	0	23.00
24.00	Accumulated depreciation	-44,379,494	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)	50,699,291	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	34,776,704	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	5,996,402	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	40,773,106	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	127,649,695	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	5,096,504	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,408,777	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	61,410	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,625,138	0	0	0	43.00
44.00	Other current liabilities	3,519,384	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,711,213	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,975,116	0	0	0	47.00
48.00	Unsecured loans	3,551,583	0	0	0	48.00
49.00	Other long term liabilities	4,200,283	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,726,982	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	41,438,195	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	86,211,500				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	86,211,500	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	127,649,695	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 260025

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

Worksheet G-1

Date/Time Prepared:
2/27/2014 2:08 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		75,732,803			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,812,539				2.00
3.00	Total (sum of line 1 and line 2)		85,545,342			0	3.00
4.00	PRIOR PERIOD ADJUSTMENT	666,158		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		666,158			0	10.00
11.00	Subtotal (line 3 plus line 10)		86,211,500			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		86,211,500			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	PRIOR PERIOD 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: 260025

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2014 2:08 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,316,943		6,316,943	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)	6,316,943		6,316,943	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,771,116		1,771,116	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)	1,771,116		1,771,116	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,088,059		8,088,059	17.00
18.00	Ancillary services	125,536,187	119,429,259	244,965,446	18.00
19.00	Outpatient services	733,174	2,488,346	3,221,520	19.00
20.00	RURAL HEALTH CLINIC	0	823,542	823,542	20.00
20.01	RURAL HEALTH CLINIC II	0	738,082	738,082	20.01
20.02	RURAL HEALTH CLINIC III	0	1,151,348	1,151,348	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		927,826	927,826	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	2,070,902	2,585,293	4,656,195	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	12,026,591	12,026,591	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	136,428,322	140,170,287	276,598,609	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,167,860		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		110,167,860		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 260025

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

Worksheet G-3

Date/Time Prepared:
2/27/2014 2:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	276,598,609	1.00
2.00	Less contractual allowances and discounts on patients' accounts	159,570,912	2.00
3.00	Net patient revenues (line 1 minus line 2)	117,027,697	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	110,167,860	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,859,837	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	455,392	6.00
7.00	Income from investments	52,121	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	536,142	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	0	23.00
24.00	RENTAL INCOME	281,828	24.00
24.01	NON-OPERATING INCOME	6,722,890	24.01
24.02	OTHER REVENUE	2,407,932	24.02
25.00	Total other income (sum of lines 6-24)	10,456,305	25.00
26.00	Total (line 5 plus line 25)	17,316,142	26.00
27.00	BAD DEBTS	7,503,603	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,503,603	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,812,539	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 260025

Period: From 10/01/2012

Worksheet H

HHA CCN: 267282

To 09/30/2013

Date/Time Prepared: 2/27/2014 2:08 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
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	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	188,629	23,785	0	0	131,968	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	302,530	38,148	0	0	9,077	6.00
7.00	Physical Therapy	175,993	22,192	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	5,566	8.00
9.00	Speech Pathology	7,190	907	0	0	536	9.00
10.00	Medical Social Services	1,361	172	0	0	0	10.00
11.00	Home Health Aide	62,698	7,906	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	14,178	12.00
13.00	Drugs	0	0	0	0	189	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)	738,401	93,110	0	0	161,514	24.00
	Reclassification	Reclassified 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	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	344,382	-33	344,349		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	349,755	0	349,755		6.00
7.00	Physical Therapy	0	198,185	0	198,185		7.00
8.00	Occupational Therapy	0	5,566	0	5,566		8.00
9.00	Speech Pathology	0	8,633	0	8,633		9.00
10.00	Medical Social Services	0	1,533	0	1,533		10.00
11.00	Home Health Aide	0	70,604	0	70,604		11.00
12.00	Supplies (see instructions)	0	14,178	0	14,178		12.00
13.00	Drugs	0	189	0	189		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	0	993,025	-33	992,992		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: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/27/2014 2:08 pm
		HHA CCN: 267282	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)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.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	344,349	0	0	0	344,349	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	349,755	0	0	0	349,755	6.00
7.00	Physical Therapy	198,185	0	0	0	198,185	7.00
8.00	Occupational Therapy	5,566	0	0	0	5,566	8.00
9.00	Speech Pathology	8,633	0	0	0	8,633	9.00
10.00	Medical Social Services	1,533	0	0	0	1,533	10.00
11.00	Home Health Aide	70,604	0	0	0	70,604	11.00
12.00	Supplies (see instructions)	14,178	0	0	0	14,178	12.00
13.00	Drugs	189	0	0	0	189	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)	992,992	0	0	0	992,992	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	344,349					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	185,676	535,431				6.00
7.00	Physical Therapy	105,212	303,397				7.00
8.00	Occupational Therapy	2,955	8,521				8.00
9.00	Speech Pathology	4,583	13,216				9.00
10.00	Medical Social Services	814	2,347				10.00
11.00	Home Health Aide	37,482	108,086				11.00
12.00	Supplies (see instructions)	7,527	21,705				12.00
13.00	Drugs	100	289				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)		992,992				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 260025

Period:

Worksheet H-1

HHA CCN: 267282

From 10/01/2012

Part II

To 09/30/2013

Date/Time Prepared:

Home Health Agency I

2/27/2014 2:08 pm
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	100			0		1.00
2.00	Capital Related - Movable Equipment		100		0		2.00
3.00	Plant Operation & Maintenance	0	0	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	100	100	100	100	-344,349	648,643
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	349,755
7.00	Physical Therapy	0	0	0	0	0	198,185
8.00	Occupational Therapy	0	0	0	0	0	5,566
9.00	Speech Pathology	0	0	0	0	0	8,633
10.00	Medical Social Services	0	0	0	0	0	1,533
11.00	Home Health Aide	0	0	0	0	0	70,604
12.00	Supplies (see instructions)	0	0	0	0	0	14,178
13.00	Drugs	0	0	0	0	0	189
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	100	100	100	100	-344,349	648,643
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		344,349
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.530876

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 267282

To 09/30/2013

Part I
Date/Time Prepared: 2/27/2014 2:08 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	0	4,093	51,345	55,438	19,126	1.00
2.00 Skilled Nursing Care	535,431	0	0	82,350	617,781	213,139	2.00
3.00 Physical Therapy	303,397	0	0	47,905	351,302	121,202	3.00
4.00 Occupational Therapy	8,521	0	0	0	8,521	2,940	4.00
5.00 Speech Pathology	13,216	0	0	1,957	15,173	5,235	5.00
6.00 Medical Social Services	2,347	0	0	370	2,717	937	6.00
7.00 Home Health Aide	108,086	0	0	17,066	125,152	43,178	7.00
8.00 Supplies (see instructions)	21,705	0	0	0	21,705	7,488	8.00
9.00 Drugs	289	0	0	0	289	100	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)	992,992	0	4,093	200,993	1,198,078	413,345	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		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	7,114	53,788	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) (2)	7,114	53,788	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 267282

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 2:08 pm

Home Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		13.00	14.00	15.00	16.00	19.00	24.00	
1.00	Administrative and General	0	0	0	0	0	135,466	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	830,920	2.00
3.00	Physical Therapy	0	0	0	0	0	472,504	3.00
4.00	Occupational Therapy	0	0	0	0	0	11,461	4.00
5.00	Speech Pathology	0	0	0	0	0	20,408	5.00
6.00	Medical Social Services	0	0	0	0	0	3,654	6.00
7.00	Home Health Aide	0	0	0	0	0	168,330	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	29,193	8.00
9.00	Drugs	0	0	0	0	0	389	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	0	0	0	1,672,325	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		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	135,466					1.00
2.00	Skilled Nursing Care	0	830,920	73,242	904,162			2.00
3.00	Physical Therapy	0	472,504	41,649	514,153			3.00
4.00	Occupational Therapy	0	11,461	1,010	12,471			4.00
5.00	Speech Pathology	0	20,408	1,799	22,207			5.00
6.00	Medical Social Services	0	3,654	322	3,976			6.00
7.00	Home Health Aide	0	168,330	14,837	183,167			7.00
8.00	Supplies (see instructions)	0	29,193	2,573	31,766			8.00
9.00	Drugs	0	389	34	423			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,672,325	135,466	1,672,325			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.			0.088145				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: 260025 HHA CCN: 267282	Period: From 10/01/2012 To 09/30/2013	Worksheet H-2 Part II Date/Time Prepared: 2/27/2014 2:08 pm
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	3,845	188,629	0	55,438	3,650	1.00
2.00 Skilled Nursing Care	0	0	302,530	0	617,781	0	2.00
3.00 Physical Therapy	0	0	175,993	0	351,302	0	3.00
4.00 Occupational Therapy	0	0	0	0	8,521	0	4.00
5.00 Speech Pathology	0	0	7,190	0	15,173	0	5.00
6.00 Medical Social Services	0	0	1,361	0	2,717	0	6.00
7.00 Home Health Aide	0	0	62,698	0	125,152	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	21,705	0	8.00
9.00 Drugs	0	0	0	0	289	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	3,845	738,401		1,198,078	3,650	20.00
21.00 Total cost to be allocated	0	4,093	200,993		413,345	7,114	21.00
22.00 Unit cost multiplier	0.000000	1.064499	0.272200		0.345007	1.949041	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	3,650	0	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)	3,650	0	0	0	0	0	20.00
21.00 Total cost to be allocated	53,788	0	0	0	0	0	21.00
22.00 Unit cost multiplier	14.736438	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 260025

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 267282

To 09/30/2013

Part II
Date/Time Prepared:
2/27/2014 2:08 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS					Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/27/2014 2:08 pm	
					Title XVII I	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 (col. 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	904,162		904,162	3,581	252.49	1.00
2.00	Physical Therapy	3.00	514,153	0	514,153	2,056	250.07	2.00
3.00	Occupational Therapy	4.00	12,471	0	12,471	0	0.00	3.00
4.00	Speech Pathology	5.00	22,207	0	22,207	84	264.37	4.00
5.00	Medical Social Services	6.00	3,976		3,976	11	361.45	5.00
6.00	Home Health Aide	7.00	183,167		183,167	620	295.43	6.00
7.00	Total (sum of lines 1-6)		1,640,136	0	1,640,136	6,352		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
0 1.00 2.00 3.00 4.00 5.00								
Limitation Cost Computation								
8.00	Skilled Nursing Care		99926	982	488			8.00
8.01	Skilled Nursing Care		99914	139	230			8.01
9.00	Physical Therapy		99926	532	336			9.00
9.01	Physical Therapy		99914	88	195			9.01
10.00	Occupational Therapy		99926	0	0			10.00
10.01	Occupational Therapy		99914	0	0			10.01
11.00	Speech Pathology		99926	61	0			11.00
11.01	Speech Pathology		99914	0	1			11.01
12.00	Medical Social Services		99926	3	3			12.00
12.01	Medical Social Services		99914	0	1			12.01
13.00	Home Health Aide		99926	318	122			13.00
13.01	Home Health Aide		99914	10	13			13.01
14.00	Total (sum of lines 8-13)			2,133	1,389			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 (col. 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	31,766	0	31,766	47,129	0.674022	15.00
16.00	Cost of Drugs	9.00	423	0	423	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Part A								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
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	1,121	718		283,041	181,288		1.00
2.00	Physical Therapy	620	531		155,043	132,787		2.00
3.00	Occupational Therapy	0	0		0	0		3.00
4.00	Speech Pathology	61	1		16,127	264		4.00
5.00	Medical Social Services	3	4		1,084	1,446		5.00
6.00	Home Health Aide	328	135		96,901	39,883		6.00
7.00	Total (sum of lines 1-6)	2,133	1,389		552,196	355,668		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025
HHA CCN: 267282

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

Worksheet H-3
Part I
Date/Time Prepared:
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Title XVII

Home Health Agency I

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
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00
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		0	0		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	464,329					1.00
2.00	Physical Therapy	287,830					2.00
3.00	Occupational Therapy	0					3.00
4.00	Speech Pathology	16,391					4.00
5.00	Medical Social Services	2,530					5.00
6.00	Home Health Aide	136,784					6.00
7.00	Total (sum of lines 1-6)	907,864					7.00
Cost Center Description		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part II Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Home Health Agency I	PPS

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	1.038307	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	1.291131	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.115807	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.152784	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2014 2:08 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	0	0
2.00	Total charges	0	0	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	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	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	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		297,341	247,365
12.00	Total PPS Reimbursement - Full Episodes with Outliers		6,471	2,391
13.00	Total PPS Reimbursement - LUPA Episodes		4,509	5,522
14.00	Total PPS Reimbursement - PEP Episodes		2,737	1,699
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		2,399	1,315
16.00	Total PPS Outlier Reimbursement - PEP Episodes		27	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	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		313,484	258,292
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		313,484	258,292
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		313,484	258,292
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)		313,484	258,292
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		313,484	258,292
31.01	Sequestration adjustment (see instructions)		1,942	1,860
32.00	Interim payments (see instructions)		311,542	256,432
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	0
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: 260025
HHA CCN: 267282

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

Worksheet H-5
Date/Time Prepared: 2/27/2014 2:08 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		311,542		256,432	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)		311,542		256,432	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		1,942		1,860	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		313,484		258,292	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,327,803	1.00
2.00	Capital DRG outlier payments		76,051	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		44.74	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,403,854	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/27/2014 2:08 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	255,790	0	255,790	0	255,790	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	122,160	0	122,160	0	122,160	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	108,075	0	108,075	0	108,075	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)	486,025	0	486,025	0	486,025	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	17,011	17,011	0	17,011	13.00
14.00	Subtotal (sum of lines 11-13)	0	17,011	17,011	0	17,011	14.00
15.00	Medical Supplies	0	3,407	3,407	0	3,407	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	16,215	16,215	0	16,215	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	19,622	19,622	0	19,622	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	486,025	36,633	522,658	0	522,658	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	44	44	0	44	29.00
30.00	Administrative Costs	127,679	172,963	300,642	0	300,642	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	127,679	173,007	300,686	0	300,686	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	613,704	209,640	823,344	0	823,344	32.00

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

Provider CCN: 260025

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

Worksheet M-1

Component CCN: 268512

Date/Time Prepared:
2/27/2014 2:08 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	255,790	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	122,160	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	108,075	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	486,025	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	17,011	13.00
14.00	Subtotal (sum of lines 11-13)	0	17,011	14.00
15.00	Medical Supplies	0	3,407	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	16,215	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	19,622	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	522,658	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	44	29.00
30.00	Administrative Costs	-506	300,136	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-506	300,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-506	822,838	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/27/2014 2:08 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassified	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	198,706	0	198,706	0	198,706	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	101,559	0	101,559	0	101,559	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	80,495	0	80,495	0	80,495	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)	380,760	0	380,760	0	380,760	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	301	301	0	301	13.00
14.00	Subtotal (sum of lines 11-13)	0	301	301	0	301	14.00
15.00	Medical Supplies	0	4,840	4,840	0	4,840	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	17,287	17,287	0	17,287	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	22,127	22,127	0	22,127	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	380,760	22,428	403,188	0	403,188	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	81,854	87,455	169,309	0	169,309	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	81,854	87,455	169,309	0	169,309	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	462,614	109,883	572,497	0	572,497	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1
	Component CCN: 263984		Date/Time Prepared: 2/27/2014 2:08 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	198,706	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	101,559	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	80,495	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	0	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	0	9.00
10.00 Subtotal (sum of lines 1-9)	0	380,760	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	301	13.00
14.00 Subtotal (sum of lines 11-13)	0	301	14.00
15.00 Medical Supplies	0	4,840	15.00
16.00 Transportation (Health Care Staff)	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	17,287	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15-20)	0	22,127	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	403,188	22.00
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	0	0	29.00
30.00 Administrative Costs	-756	168,553	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-756	168,553	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-756	571,741	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/27/2014 2:08 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	241,395	0	241,395	0	241,395	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	91,217	0	91,217	0	91,217	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	92,163	0	92,163	0	92,163	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)	424,775	0	424,775	0	424,775	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	33,616	33,616	0	33,616	13.00
14.00	Subtotal (sum of lines 11-13)	0	33,616	33,616	0	33,616	14.00
15.00	Medical Supplies	0	4,080	4,080	0	4,080	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	32,943	32,943	0	32,943	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	37,023	37,023	0	37,023	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	424,775	70,639	495,414	0	495,414	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	124,669	114,480	239,149	0	239,149	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	124,669	114,480	239,149	0	239,149	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	549,444	185,119	734,563	0	734,563	32.00

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

Provider CCN: 260025

Period:

Worksheet M-1

Component CCN: 268513

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

Date/Time Prepared:
2/27/2014 2:08 pm

Rural Health
Clinic (RHC) III

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	241,395	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	91,217	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	92,163	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	424,775	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	33,616	13.00
14.00	Subtotal (sum of lines 11-13)	0	33,616	14.00
15.00	Medical Supplies	0	4,080	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	32,943	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	37,023	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	495,414	22.00
COSTS OTHER THAN RHC/FOHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-285	238,864	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-285	238,864	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-285	734,278	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2012 To 09/30/2013	Worksheet M-2 Date/Time Prepared: 2/27/2014 2:08 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	1.49	3,180	4,200	6,258	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.17	1,671	2,100	2,457	3.00
4.00	Subtotal (sum of lines 1-3)	2.66	4,851		8,715	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)	2.66	4,851		8,715	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)				522,658	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)				522,658	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)				300,180	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				471,753	15.00
16.00	Total overhead (sum of lines 14 and 15)				771,933	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				771,933	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				771,933	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,294,591	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2012 To 09/30/2013	Worksheet M-2 Date/Time Prepared: 2/27/2014 2:08 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	0.85	2,248	4,200	3,570	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.84	2,281	2,100	1,764	3.00
4.00	Subtotal (sum of lines 1-3)	1.69	4,529		5,334	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)	1.69	4,529		5,334	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)				403,188	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)				403,188	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)				168,553	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				418,990	15.00
16.00	Total overhead (sum of lines 14 and 15)				587,543	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				587,543	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				587,543	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				990,731	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2012 To 09/30/2013	Worksheet M-2 Date/Time Prepared: 2/27/2014 2:08 pm		
			Rural Health Clinic (RHC) III	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	0.85	3,448	4,200	3,570	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.80	1,621	2,100	1,680	3.00
4.00	Subtotal (sum of lines 1-3)	1.65	5,069		5,250	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)	1.65	5,069		5,250	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)				495,414	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)				495,414	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)				238,864	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				476,216	15.00
16.00	Total overhead (sum of lines 14 and 15)				715,080	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				715,080	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				715,080	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,210,494	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-3
		Component CCN: 268512		Date/Time Prepared: 2/27/2014 2:08 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)		1,294,591	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		25,986	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,268,605	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		8,715	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)		8,715	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		145.57	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)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	361	1,085	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	28,353	85,899	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	79	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	64	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) *		114,316	16.00
16.01	Total program charges (see instructions)(from contractor's records)		192,040	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		436	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		259	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.)		71,294	16.04
16.05	Total program cost (see instructions)		71,553	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,940	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,327	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		71,553	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,510	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		89,063	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		89,063	26.00
26.01	Sequestration adjustment (see instructions)		891	26.01
27.00	Interim payments		73,867	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		14,305	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-3
		Component CCN: 263984		Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	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)		990,731	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		17,643	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		973,088	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,334	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)		5,334	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.43	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)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	296	886	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	23,248	70,145	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	61	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	4,829	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	3,924	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) *		97,317	16.00
16.01	Total program charges (see instructions)(from contractor's records)		162,691	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		706	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		422	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.)		61,202	16.04
16.05	Total program cost (see instructions)		61,624	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,393	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,686	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		61,624	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,948	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		73,572	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		73,572	26.00
26.01	Sequestration adjustment (see instructions)		736	26.01
27.00	Interim payments		63,915	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		8,921	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-3
		Component CCN: 268513		Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Rural Health Clinic (RHC) III	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)		1,210,494	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		45,256	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,165,238	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,250	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)		5,250	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		221.95	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)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	388	1,164	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	30,474	92,154	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	79	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	64	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) *		122,692	16.00
16.01	Total program charges (see instructions)(from contractor's records)		235,244	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.)		78,838	16.04
16.05	Total program cost (see instructions)		78,838	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,145	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		42,220	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		78,838	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		25,652	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		104,490	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		104,490	26.00
26.01	Sequestration adjustment (see instructions)		1,045	26.01
27.00	Interim payments		82,394	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		21,051	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4 Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	486,025	486,025	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000692	0.007313	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	336	3,554	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,956	3,645	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,292	7,199	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	522,658	522,658	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	771,933	771,933	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006299	0.013774	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,862	10,633	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,154	17,832	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	243	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	354.52	73.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	142	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	7,090	10,420	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		25,986	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		17,510	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4 Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	380,760	380,760	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000371	0.008537	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	141	3,251	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,028	2,760	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,169	6,011	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	403,188	403,188	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	587,543	587,543	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002899	0.014909	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,703	8,760	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,872	14,771	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	8	184	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	359.00	80.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	122	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,154	9,794	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		17,643	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		11,948	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4 Date/Time Prepared: 2/27/2014 2:08 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	424,775	424,775	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002566	0.011771	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,090	5,000	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,097	4,335	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,187	9,335	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	495,414	495,414	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	715,080	715,080	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018544	0.018843	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,260	13,474	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	22,447	22,809	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	63	289	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	356.30	78.92	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	37	158	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,183	12,469	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		45,256	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		25,652	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2012 To 09/30/2013	Worksheet M-5 Date/Time Prepared: 2/27/2014 2:08 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		73,867	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)		73,867	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		14,305	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		88,172	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: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-5
	Component CCN: 263984	Rural Health Clinic (RHC) II	Date/Time Prepared: 2/27/2014 2:08 pm

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		63,915	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)		63,915	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		8,921	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		72,836	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: 260025	Period: From 10/01/2012 To 09/30/2013	Worksheet M-5
	Component CCN: 268513	Rural Health Clinic (RHC) III	Date/Time Prepared: 2/27/2014 2:08 pm Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		82,394	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)		82,394	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		21,051	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		103,445	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

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