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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet S Parts I-III Date/Time Prepared: 6/25/2013 9:26 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/25/2013 Time: 9:26 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 MERCER COUNTY HOSPITAL (141304) for the cost reporting period beginning 07/01/2012 and ending 01/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	46,118	158,784	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	24,280	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		27,281		0	10.00
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	70,398	186,065	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 6/25/2013 9:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MERCER COUNTY HOSPITAL	141304	19340	1	05/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MERCER COUNTY HOSPITAL	14Z304	19340		05/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MERCER COUNTY HOSPITAL	147462	19340		01/06/1987	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MERCER COUNTY HOSPITAL	141593	19340		09/05/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	MERCER COUNTY HOSPITAL	143453	19340		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	01/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	78,182	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05101	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet S-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 6/25/2013 9:22 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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.	N			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.	N			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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/14/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 6/25/2013 9:22 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BRENT	DAILY	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-1985	DAILYBR@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 6/25/2013 9:22 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/14/2013			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER, REIMBURSEMENT		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: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 6/25/2013 9:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	22	4,730	7,841.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					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)		22	4,730	7,841.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	4,730	7,841.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						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	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		22				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)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	300	6	389			1.00
2.00	HMO	31	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	354	0	428			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	4			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	654	6	821			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)	654	6	821	0.00	98.37	14.00
15.00	CAH visits	4,727	1,489	11,259			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,051	46	1,422	0.00	6.06	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.14	24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,913	2,299	8,682	0.00	13.97	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 6/25/2013 9:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	118.54	27.00
28.00	Observation Bed Days		23	255			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			1			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	98	4	135	1.00
2.00	HMO			12			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	98	4	135	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						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	0.00					24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141304 | Component CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-4 | Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | PPS

		1.00	
0.00	County	MERCER	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	368	0	62	430	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	46.00	2.00	14.00	62.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.53	0.00	1.53	5.00
6.00	Direct Nursing Service		1.52	0.00	1.52	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.95	0.00	0.95	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		19340			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	422	0	17	17	456	21.00
22.00	Skilled Nursing Visit Charges	126,239	0	5,078	5,101	136,418	22.00
23.00	Physical Therapy Visits	99	0	0	0	99	23.00
24.00	Physical Therapy Visit Charges	13,458	0	0	0	13,458	24.00
25.00	Occupational Therapy Visits	38	0	0	0	38	25.00
26.00	Occupational Therapy Visit Charges	5,599	0	0	0	5,599	26.00
27.00	Speech Pathology Visits	1	0	0	0	1	27.00
28.00	Speech Pathology Visit Charges	136	0	0	0	136	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	457	0	0	0	457	31.00
32.00	Home Health Aide Visit Charges	28,101	0	0	0	28,101	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,017	0	17	17	1,051	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)	173,533	0	5,078	5,101	183,712	35.00
36.00	Total Number of Episodes (standard/non outlier)	56		7	1	64	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	3,003	0	327	126	3,456	38.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-8 | Date/Time Prepared: 6/25/2013 9:22 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1007 NW 3RD STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	ALEDO		IL	61231	2.00
					1.00	
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
9.02				0		9.02
9.03				0		9.03
9.04				0		9.04
9.05				0		9.05
9.06				0		9.06
9.07				0		9.07
9.08				0		9.08
9.09				0		9.09
9.10				0		9.10
9.11				0		9.11
9.12				0		9.12
				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	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	17:30	07:30	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. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

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

Provider CCN: 141304 Component CCN: 143453

Period: From 07/01/2012 To 01/31/2013

Worksheet S-8 Date/Time Prepared: 6/25/2013 9:22 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		MERCER				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:30	07:30	17:30	07:30	17:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	17:30				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 141304 Component CCN: 141593	Period: From 07/01/2012 To 01/31/2013	Worksheet S-9 Parts I & II Date/Time Prepared: 6/25/2013 9:22 am
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	99	3	0	0	6	108	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	99	3	0	0	6	108	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	5	1	0	0	1	7	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	19.80	3.00	0.00	0.00	6.00	15.43	8.00
9.00	Unduplicated Census Count	4	1	0	0	1	6	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet S-10 | Date/Time Prepared: 6/25/2013 9:22 am

		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)	0.638508	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	599,443	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,164,458	6.00
7.00	Medicaid cost (line 1 times line 6)	743,516	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)	144,073	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	4,888	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)	144,073	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	333,955	0	333,955	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	213,233	0	213,233	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	213,233	0	213,233	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)	489,715	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	83,439	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	406,276	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	259,410	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	472,643	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	616,716	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		52,241	52,241	12,290	64,531	1.00
1.01	00101	FOUNDATION BLDG		0	0	40,806	40,806	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		150,959	150,959	26,838	177,797	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		245,417	245,417	-245,417	0	3.00
4.00	00400	EMPLOYEE BENEFITS	54,216	804,442	858,658	0	858,658	4.00
5.01	00510	ADMITTING	68,279	7,562	75,841	0	75,841	5.01
5.02	00511	HOSPITAL ONLY A&G	122,894	181,946	304,840	0	304,840	5.02
5.03	00560	SHARED ADMN & GENERAL	136,735	409,038	545,773	448,658	994,431	5.03
6.00	00600	MAINTENANCE & REPAIRS	114,367	75,253	189,620	0	189,620	6.00
7.00	00700	OPERATION OF PLANT	0	142,339	142,339	0	142,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,508	18,871	20,379	0	20,379	8.00
9.00	00900	HOUSEKEEPING	45,584	12,684	58,268	0	58,268	9.00
10.00	01000	DIETARY	88,217	87,411	175,628	0	175,628	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	59,222	5,871	65,093	0	65,093	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	672	28,468	29,140	0	29,140	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,767	47,007	70,774	0	70,774	16.00
17.00	01700	SOCIAL SERVICE	30,948	2,456	33,404	0	33,404	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	105,000	105,000	0	105,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	525,328	75,870	601,198	0	601,198	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,866	27,760	43,626	0	43,626	50.00
53.00	05300	ANESTHESIOLOGY	0	338	338	0	338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	241,273	108,925	350,198	0	350,198	54.00
56.00	05600	RADIOISOTOPE	0	66,416	66,416	0	66,416	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	66,450	66,450	58.00
60.00	06000	LABORATORY	213,600	331,962	545,562	-10,391	535,171	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	10,391	10,391	63.00
65.00	06500	RESPIRATORY THERAPY	80,324	23,468	103,792	0	103,792	65.00
66.00	06600	PHYSICAL THERAPY	133,095	16,572	149,667	0	149,667	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,280	26,280	0	26,280	67.00
68.00	06800	SPEECH PATHOLOGY	0	900	900	0	900	68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,181	81,181	-66,450	14,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,514	238,122	346,636	0	346,636	73.00
76.00	03950	SLEEP LAB	0	19,434	19,434	0	19,434	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	616,057	511,891	1,127,948	-194,029	933,919	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	262,009	552,248	814,257	0	814,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	146,834	53,151	199,985	-14,984	185,001	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		26,951	26,951	-26,951	0	113.00
116.00	11600	HOSPICE	3,796	13,265	17,061	0	17,061	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,093,105	4,551,699	7,644,804	47,211	7,692,015	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	125,047	96,339	221,386	-47,211	174,175	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	3,218,152	4,648,038	7,866,190	0	7,866,190	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	64,531		1.00
1.01	00101	FOUNDATION BLDG	-9,795	31,011		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-21	177,776		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-2,292	856,366		4.00
5.01	00510	ADMITTING	0	75,841		5.01
5.02	00511	HOSPITAL ONLY A&G	0	304,840		5.02
5.03	00560	SHARED ADMN & GENERAL	730,050	1,724,481		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	189,620		6.00
7.00	00700	OPERATION OF PLANT	0	142,339		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,379		8.00
9.00	00900	HOUSEKEEPING	0	58,268		9.00
10.00	01000	DIETARY	-24,461	151,167		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	65,093		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-252	28,888		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,187	54,587		16.00
17.00	01700	SOCIAL SERVICE	0	33,404		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-105,000	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-25,822	575,376		30.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	43,626		50.00
53.00	05300	ANESTHESIOLOGY	0	338		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	350,198		54.00
56.00	05600	RADIOISOTOPE	0	66,416		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	66,450		58.00
60.00	06000	LABORATORY	-436	534,735		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	10,391		63.00
65.00	06500	RESPIRATORY THERAPY	-15	103,777		65.00
66.00	06600	PHYSICAL THERAPY	0	149,667		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,280		67.00
68.00	06800	SPEECH PATHOLOGY	0	900		68.00
69.00	06900	ELECTROCARDIOLOGY	-7,840	6,891		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-124,084	222,552		73.00
76.00	03950	SLEEP LAB	0	19,434		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	848	934,767		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-77,878	736,379		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	185,001		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	17,061		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	336,815	8,028,830		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-63,731	110,444		192.00
194.00	07950	BOARD OF HEALTH	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0		194.01
194.02	07952	MOBILE MEALS	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	273,084	8,139,274		200.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-6 | Date/Time Prepared: 6/25/2013 9:22 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	6,929		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	20,022		2.00
	TOTALS		0	26,951		
	B - MRI					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	66,450		1.00
	TOTALS		0	66,450		
	C - RENT PAID TO FOUNDATION					
1.00	FOUNDATION BLDG	1.01	0	40,806		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	40,806		
	D - RHC AND HHA SALARY					
1.00	SHARED ADMN & GENERAL	5.03	67,525	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		67,525	0		
	E - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	2,256	8,135		1.00
	TOTALS		2,256	8,135		
	F - MALPRACTICE INSURANCE					
1.00	SHARED ADMN & GENERAL	5.03	0	385,783		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	385,783		
500.00	Grand Total: Increases		69,781	528,125		500.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-6 | Date/Time Prepared: 6/25/2013 9:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	26,951	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	26,951			
	B - MRI						
1.00	ELECTROCARDIOLOGY	69.00	0	66,450	0		1.00
	TOTALS		0	66,450			
	C - RENT PAID TO FOUNDATION						
1.00	SHARED ADMN & GENERAL	5.03	0	4,650	9		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	36,156	0		2.00
	TOTALS		0	40,806			
	D - RHC AND HHA SALARY						
1.00	RURAL HEALTH CLINIC	88.00	52,541	0	0		1.00
2.00	HOME HEALTH AGENCY	101.00	14,984	0	0		2.00
	TOTALS		67,525	0			
	E - BLOOD						
1.00	LABORATORY	60.00	2,256	8,135	0		1.00
	TOTALS		2,256	8,135			
	F - MALPRACTICE INSURANCE						
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	233,240	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	105,332	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	47,211	0		3.00
	TOTALS		0	385,783			
500.00	Grand Total: Decreases		69,781	528,125			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 6/25/2013 9:22 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	43,583	0	0	0	0	1.00
2.00	Land Improvements	24,966	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,925,701	683,830	0	683,830	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,991,602	869,502	0	869,502	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,985,852	1,553,332	0	1,553,332	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,985,852	1,553,332	0	1,553,332	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	43,583	0	1.00
2.00	Land Improvements	24,966	0	2.00
3.00	Buildings and Fixtures	4,609,531	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,861,104	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,539,184	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	10,539,184	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 6/25/2013 9:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	52,241	0	0	0	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	150,959	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	203,200	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	52,241		1.00
1.01	FOUNDATION BLDG	0	0		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	150,959		2.00
3.00	Total (sum of lines 1-2)	0	203,200		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 6/25/2013 9:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,609,531	0	4,609,531	0.440234	5,361	1.00
1.01	FOUNDATION BLDG	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,861,104	0	5,861,104	0.559766	6,816	2.00
3.00	Total (sum of lines 1-2)	10,470,635	0	10,470,635	1.000000	12,177	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	5,361	59,170	0	1.00
1.01	FOUNDATION BLDG	0	0	0	31,011	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	6,816	170,960	0	2.00
3.00	Total (sum of lines 1-2)	0	0	12,177	261,141	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,361	0	0	64,531	1.00
1.01	FOUNDATION BLDG	0	0	0	0	31,011	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	6,816	0	0	177,776	2.00
3.00	Total (sum of lines 1-2)	0	12,177	0	0	273,318	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8 | Date/Time Prepared: 6/25/2013 9:22 am

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - FOUNDATION BLDG (chapter 2)		0	FOUNDATION BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-106,790			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	775,281			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - FOUNDATION BLDG		0	FOUNDATION BLDG	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8 | Date/Time Prepared: 6/25/2013 9:22 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SERVICE CHARGE REVENUE	B	-14,303	SHARED ADMN & GENERAL	5.03	0	33.00
34.00	CAFETERIA REVENUE	B	-21,924	DIETARY	10.00	0	34.00
35.00	MISC REV - DIET	B	-1,465	DIETARY	10.00	0	35.00
36.00	VENDING REVENUE	B	-1,072	DIETARY	10.00	0	36.00
37.00	MISC REV - MED RECORDS	B	-3,626	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	DISCOUNTS TAKEN	B	-78	SHARED ADMN & GENERAL	5.03	0	38.00
39.00	MISC REV - PHARMACY	B	-124,084	DRUGS CHARGED TO PATIENTS	73.00	0	39.00
40.00	MISC REV - LAB	B	-126	LABORATORY	60.00	0	40.00
41.00	MISC REV - CARDIO	B	-15	RESPIRATORY THERAPY	65.00	0	41.00
42.00	MISC REV - SUPPLIES	B	-252	CENTRAL SERVICES & SUPPLY	14.00	0	42.00
43.00	VENDOR REBATES	B	-487	SHARED ADMN & GENERAL	5.03	0	43.00
44.00	MCNH LEASED EMPLOYEES	B	-25,822	ADULTS & PEDIATRICS	30.00	0	44.00
45.00	OFFSET EX UNSHELT BOND SINK	A	-21	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	45.00
45.01	PATIENT PHONES SALARY	A	-215	SHARED ADMN & GENERAL	5.03	0	45.01
45.02	PATIENT PHONES BENEFITS	A	-57	EMPLOYEE BENEFITS	4.00	0	45.02
45.03	PATIENT PHONES COST	A	-847	SHARED ADMN & GENERAL	5.03	0	45.03
45.04	LOBBYING EXPENSE	A	-5,901	SHARED ADMN & GENERAL	5.03	0	45.04
45.05	ADVERTISING	A	-16,892	SHARED ADMN & GENERAL	5.03	0	45.05
45.06	ADVERTISING	A	-310	LABORATORY	60.00	0	45.06
45.07	ADVERTISING	A	-2,196	RURAL HEALTH CLINIC	88.00	0	45.07
45.08	COUNTRY CLUB MEMBERSHIP	A	-252	SHARED ADMN & GENERAL	5.03	0	45.08
45.09	CRNA FEES AFTER 1/1/07	A	-105,000	NONPHYSICIAN ANESTHETISTS	19.00	0	45.09
45.10	OCCUPATIONAL HEALTH	A	-2,235	EMPLOYEE BENEFITS	4.00	0	45.10
45.11	PROFESSIONAL FEES OFFSET 100% PART B	A	-68,227	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		273,084				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 6/25/2013 9:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	FOUNDATION BLDG	RENT EXPENSE	31,011	40,806	1.00
2.00	5.03	SHARED ADMN & GENERAL	GHS - MANAGEMENT SERVICES	805,009	94,800	2.00
3.00	5.03	SHARED ADMN & GENERAL	GHS - IT FEES	108,816	50,000	3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	GHS - HIM FEES	12,609	25,170	4.00
4.01	88.00	RURAL HEALTH CLINIC	GHS - GHG CLINIC	65,047	40,931	4.01
4.02	65.00	RESPIRATORY THERAPY	GMC - SLEEP LAB	16,475	16,475	4.02
4.03	4.00	EMPLOYEE BENEFITS	GENESIS EAP	700	700	4.03
4.04	60.00	LABORATORY	GENESIS OCC HLTH - DRUG SCRN	1,463	1,463	4.04
4.06	5.03	SHARED ADMN & GENERAL	GMC SUPPLIES	31	31	4.06
4.10	50.00	OPERATING ROOM	GMC SUPPLIES	142	142	4.10
4.11	73.00	DRUGS CHARGED TO PATIENTS	GMC SUPPLIES	5,016	5,016	4.11
4.12	60.00	LABORATORY	GMC MAINTENANCE	1,108	1,108	4.12
4.13	91.00	EMERGENCY	GMC MAINTENANCE	1,680	1,680	4.13
4.14	66.00	PHYSICAL THERAPY	GMC MAINTENANCE	1,287	1,287	4.14
4.15	30.00	ADULTS & PEDIATRICS	GMC MAINTENANCE	4,436	4,436	4.15
4.16	50.00	OPERATING ROOM	GMC MAINTENANCE	1,212	1,212	4.16
4.17	54.00	RADIOLOGY-DIAGNOSTIC	GMC MAINTENANCE	872	872	4.17
4.18	65.00	RESPIRATORY THERAPY	GMC MAINTENANCE	1,474	1,474	4.18
4.19	88.00	RURAL HEALTH CLINIC	GMC MAINTENANCE	3,729	3,729	4.19
4.20	76.00	SLEEP LAB	GMC MAINTENANCE	701	701	4.20
4.21	6.00	MAINTENANCE & REPAIRS	GMC MAINTENANCE	561	561	4.21
4.22	88.00	RURAL HEALTH CLINIC	CONTRACTED PHYSICIAN	61,370	61,370	4.22
4.24	88.00	RURAL HEALTH CLINIC	CONTRACTED PHYSICIAN	109,570	109,570	4.24
4.25	192.00	PHYSICIANS' PRIVATE OFFICES	GHS - GHG CLINIC	12,126	7,630	4.25
5.00	0		0	1,246,445	471,164	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	A	MERCER CTY HOSP	100.00	MERCER FOUNDATION FOR HTL	100.00	6.00
7.00	B	MERCER CTY HOSP	0.00	GENESIS HLTH SY	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8-1 | Date/Time Prepared: 6/25/2013 9:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-9,795	9		1.00
2.00	710,209	0		2.00
3.00	58,816	0		3.00
4.00	-12,561	0		4.00
4.01	24,116	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.06	0	0		4.06
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	4,496	0		4.25
5.00	775,281			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	NOT-FOR PROFIT		6.00
7.00	NOT-FOR PROFIT		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 6/25/2013 9:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	503,028	77,878	425,150	0	0	1.00
2.00	88.00	RURAL HEALTH CLINIC	575,636	21,072	554,564	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	7,840	7,840	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,086,504	106,790	979,714		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	77,878		1.00
2.00	88.00	RURAL HEALTH CLINIC	0	0	0	21,072		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	7,840		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	106,790		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/25/2013 9:22 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					7	1.00
2.00	Line 1 multiplied by 15 hours per week					105	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					126	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	102.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	86.34	69.07	51.80	34.54	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.54	34.54	25.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,080	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,080	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,080	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.07	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					7,252	22.00
23.00	Total salary equivalency (see instructions)					7,252	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,352	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,352	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					693	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,045	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,045	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.07	51.80	34.54	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	7,252		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,045		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	12,297		63.00
64.00	Total cost of outside supplier services (from your records)	2,367		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,352		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	693		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,045		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	693		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	693		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		28	1.00
2.00	Line 1 multiplied by 15 hours per week		420	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		133	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.55	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	743.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	86.34	69.07	51.80	34.54	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.54	34.54	25.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	51,336	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	51,336	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	51,336	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	51,336	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,594	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	4,594	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	732	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	5,326	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	5,326	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.07	51.80	34.54	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	51,336	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,326	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	56,662	63.00
64.00	Total cost of outside supplier services (from your records)	24,874	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,594	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	732	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,326	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	732	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	732	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					12	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	6.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	86.34	69.07	51.80	34.54	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.54	34.54	25.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					414	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					414	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					414	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,350	22.00
23.00	Total salary equivalency (see instructions)					10,350	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					414	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					414	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					66	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					480	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					480	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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		Speech Pathology	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.07	51.80	34.54	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	10,350	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	480	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	10,830	63.00
64.00	Total cost of outside supplier services (from your records)	900	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	414	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	66	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	480	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	66	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	66	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part I Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	64,531	64,531				1.00
1.01	00101	FOUNDATION BLDG	31,011	0	31,011			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	177,776			177,776		2.00
4.00	00400	EMPLOYEE BENEFITS	856,366	218	0	0	856,584	4.00
5.01	00510	ADMITTING	75,841	237	0	0	18,487	5.01
5.02	00511	HOSPITAL ONLY A&G	304,840	1,279	0	0	33,274	5.02
5.03	00560	SHARED ADMN & GENERAL	1,724,481	6,660	12,478	23,709	55,246	5.03
6.00	00600	MAINTENANCE & REPAIRS	189,620	0	0	4,347	30,965	6.00
7.00	00700	OPERATION OF PLANT	142,339	4,740	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,379	1,418	0	0	408	8.00
9.00	00900	HOUSEKEEPING	58,268	604	0	126	12,342	9.00
10.00	01000	DIETARY	151,167	3,849	0	0	23,885	10.00
11.00	01100	CAFETERIA	0	1,994	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	65,093	323	0	0	16,034	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,888	4,644	0	0	182	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,587	2,193	0	0	6,435	16.00
17.00	01700	SOCIAL SERVICE	33,404	157	0	0	8,379	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	575,376	12,097	0	26,123	142,234	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,626	4,493	0	26,362	4,296	50.00
53.00	05300	ANESTHESIOLOGY	338	200	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,198	4,319	0	61,421	65,325	54.00
56.00	05600	RADIOISOTOPE	66,416	592	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	66,450	0	0	0	0	58.00
60.00	06000	LABORATORY	534,735	2,093	0	23,354	57,222	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,391	98	0	0	611	63.00
65.00	06500	RESPIRATORY THERAPY	103,777	210	0	2,845	21,748	65.00
66.00	06600	PHYSICAL THERAPY	149,667	1,579	0	1,464	36,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,280	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	900	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,891	85	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,552	863	0	0	29,380	73.00
76.00	03950	SLEEP LAB	19,434	1,535	0	5,728	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	934,767	0	13,242	863	152,573	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	736,379	3,278	0	1,434	70,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	185,001	1,156	0	0	35,698	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	17,061	327	0	0	1,028	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,028,830	61,241	25,720	177,776	822,727	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	601	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	110,444	0	0	0	33,857	192.00
194.00	07950	BOARD OF HEALTH	0	0	5,291	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	2,689	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,139,274	64,531	31,011	177,776	856,584	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part I | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	ADMITTING	Subtotal	HOSPITAL ONLY A&G	Subtotal	SHARED ADMN & GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING	94,565					5.01
5.02	00511	HOSPITAL ONLY A&G	0	339,393	339,393			5.02
5.03	00560	SHARED ADMN & GENERAL	0	1,822,574	80,887	1,903,461	1,903,461	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	224,932	9,983	234,915	71,799	6.00
7.00	00700	OPERATION OF PLANT	0	147,079	6,528	153,607	46,948	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,205	986	23,191	7,088	8.00
9.00	00900	HOUSEKEEPING	0	71,340	3,166	74,506	22,772	9.00
10.00	01000	DIETARY	0	178,901	7,940	186,841	57,106	10.00
11.00	01100	CAFETERIA	0	1,994	88	2,082	636	11.00
13.00	01300	NURSING ADMINISTRATION	0	81,450	3,615	85,065	25,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,714	1,496	35,210	10,762	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,215	2,806	66,021	20,179	16.00
17.00	01700	SOCIAL SERVICE	0	41,940	1,861	43,801	13,387	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,379	764,209	33,918	798,127	243,938	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,175	80,952	3,593	84,545	25,840	50.00
53.00	05300	ANESTHESIOLOGY	968	1,506	67	1,573	481	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,108	497,371	22,075	519,446	158,762	54.00
56.00	05600	RADIOISOTOPE	823	67,831	3,011	70,842	21,652	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,196	69,646	3,091	72,737	22,231	58.00
60.00	06000	LABORATORY	25,294	642,698	28,525	671,223	205,151	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	270	11,370	505	11,875	3,629	63.00
65.00	06500	RESPIRATORY THERAPY	1,851	130,431	5,789	136,220	41,634	65.00
66.00	06600	PHYSICAL THERAPY	4,592	193,338	8,581	201,919	61,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,217	27,497	1,220	28,717	8,777	67.00
68.00	06800	SPEECH PATHOLOGY	36	936	42	978	299	68.00
69.00	06900	ELECTROCARDIOLOGY	2,272	9,248	410	9,658	2,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,388	261,183	11,592	272,775	83,370	73.00
76.00	03950	SLEEP LAB	825	27,522	1,222	28,744	8,785	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,101,445	48,885	1,150,330	351,584	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,171	830,201	36,847	867,048	265,003	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	221,855	9,847	231,702	70,817	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	18,416	817	19,233	5,878	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,565	7,986,392	339,393	7,986,392	1,859,173	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	601	0	601	184	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	144,301	0	144,301	44,104	192.00
194.00	07950	BOARD OF HEALTH	0	5,291	0	5,291	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	2,689	0	2,689	0	194.03
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	94,565	8,139,274	339,393	8,139,274	1,903,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part I Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	306,714					6.00
7.00	00700	OPERATION OF PLANT	22,524	223,079				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,739	6,156	43,174			8.00
9.00	00900	HOUSEKEEPING	2,871	2,622	0	102,771		9.00
10.00	01000	DIETARY	18,287	16,704	0	8,011	286,949	10.00
11.00	01100	CAFETERIA	9,473	8,653	0	4,150	137,264	11.00
13.00	01300	NURSING ADMINISTRATION	1,536	1,403	0	673	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,066	20,156	0	9,666	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,422	9,520	0	4,565	0	16.00
17.00	01700	SOCIAL SERVICE	748	683	0	328	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,474	52,500	6,045	25,174	91,857	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,350	19,503	2,159	9,353	0	50.00
53.00	05300	ANESTHESIOLOGY	949	867	0	416	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,522	18,746	4,316	8,990	0	54.00
56.00	05600	RADIOISOTOPE	2,815	2,571	0	1,233	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	9,947	9,087	0	4,358	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	466	426	0	204	0	63.00
65.00	06500	RESPIRATORY THERAPY	997	911	0	437	0	65.00
66.00	06600	PHYSICAL THERAPY	7,503	6,853	12,952	3,287	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	402	367	0	176	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,101	3,746	0	1,797	0	73.00
76.00	03950	SLEEP LAB	7,294	6,662	0	3,195	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	42,829	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,577	14,228	17,271	6,823	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,492	5,017	0	2,406	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,552	1,418	431	680	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,936	208,799	43,174	95,922	229,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,608	0	1,251	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	57,828	194.02
194.03	07953	KIDNEY CENTER	12,778	11,672	0	5,598	0	194.03
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)	306,714	223,079	43,174	102,771	286,949	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part I Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
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	162,258					11.00
13.00	01300	NURSING ADMINISTRATION	2,180	116,856				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64	0	97,924			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,548	0	163	114,418		16.00
17.00	01700	SOCIAL SERVICE	2,180	3,463	21	0	64,611	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,745	64,494	4,960	10,137	59,743	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,453	2,333	5,954	2,631	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	99	1,171	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,563	0	2,764	19,489	0	54.00
56.00	05600	RADIOISOTOPE	0	0	2,734	995	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3,867	0	58.00
60.00	06000	LABORATORY	21,372	0	857	30,611	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	327	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,476	6	4,240	2,239	0	65.00
66.00	06600	PHYSICAL THERAPY	8,677	0	640	5,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	413	1,473	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	43	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	92	2,749	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,723	3,463	52,991	10,148	0	73.00
76.00	03950	SLEEP LAB	0	0	170	998	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,857	0	6,644	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	16,457	26,242	7,565	21,985	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	16,377	2,078	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	478	589	0	4,868	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	156,295	116,856	92,974	114,418	64,611	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	5,963	0	4,950	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
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)	162,258	116,856	97,924	114,418	64,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part I | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,457,194	0	1,457,194		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	175,121	0	175,121		50.00
53.00	05300	ANESTHESIOLOGY	0	5,556	0	5,556		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	769,598	0	769,598		54.00
56.00	05600	RADIOISOTOPE	0	102,842	0	102,842		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	98,835	0	98,835		58.00
60.00	06000	LABORATORY	0	952,606	0	952,606		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	16,927	0	16,927		63.00
65.00	06500	RESPIRATORY THERAPY	0	193,160	0	193,160		65.00
66.00	06600	PHYSICAL THERAPY	0	309,100	0	309,100		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	39,380	0	39,380		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,320	0	1,320		68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,396	0	16,396		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	437,114	0	437,114		73.00
76.00	03950	SLEEP LAB	0	55,848	0	55,848		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,581,244	0	1,581,244		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,258,199	0	1,258,199		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	333,889	0	333,889		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	35,127	0	35,127		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,839,456	0	7,839,456		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,644	0	4,644		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	199,318	0	199,318		192.00
194.00	07950	BOARD OF HEALTH	0	5,291	0	5,291		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	57,828	0	57,828		194.02
194.03	07953	KIDNEY CENTER	0	32,737	0	32,737		194.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,139,274	0	8,139,274		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part II Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	218	0	0	218	4.00
5.01	00510	ADMITTING	0	237	0	0	237	5.01
5.02	00511	HOSPITAL ONLY A&G	0	1,279	0	0	1,279	5.02
5.03	00560	SHARED ADMN & GENERAL	0	6,660	12,478	23,709	42,847	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	4,347	4,347	6.00
7.00	00700	OPERATION OF PLANT	0	4,740	0	0	4,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,418	0	0	1,418	8.00
9.00	00900	HOUSEKEEPING	0	604	0	126	730	9.00
10.00	01000	DIETARY	0	3,849	0	0	3,849	10.00
11.00	01100	CAFETERIA	0	1,994	0	0	1,994	11.00
13.00	01300	NURSING ADMINISTRATION	0	323	0	0	323	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,644	0	0	4,644	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,193	0	0	2,193	16.00
17.00	01700	SOCIAL SERVICE	0	157	0	0	157	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,097	0	26,123	38,220	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,493	0	26,362	30,855	50.00
53.00	05300	ANESTHESIOLOGY	0	200	0	0	200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,319	0	61,421	65,740	54.00
56.00	05600	RADIOISOTOPE	0	592	0	0	592	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,093	0	23,354	25,447	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	98	0	0	98	63.00
65.00	06500	RESPIRATORY THERAPY	0	210	0	2,845	3,055	65.00
66.00	06600	PHYSICAL THERAPY	0	1,579	0	1,464	3,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	85	0	0	85	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	863	0	0	863	73.00
76.00	03950	SLEEP LAB	0	1,535	0	5,728	7,263	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	13,242	863	14,105	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,278	0	1,434	4,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,156	0	0	1,156	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	327	0	0	327	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	61,241	25,720	177,776	264,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	601	0	0	601	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	5,291	0	5,291	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	2,689	0	0	2,689	194.03
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)	0	64,531	31,011	177,776	273,318	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part II Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	EMPLOYEE BENEFITS	ADMITTING	HOSPITAL ONLY A&G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5.02	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	218					4.00
5.01	00510	ADMITTING	5	242				5.01
5.02	00511	HOSPITAL ONLY A&G	8	0	1,287			5.02
5.03	00560	SHARED ADMN & GENERAL	14	0	307	43,168		5.03
6.00	00600	MAINTENANCE & REPAIRS	8	0	38	1,628	6,021	6.00
7.00	00700	OPERATION OF PLANT	0	0	25	1,065	442	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4	161	132	8.00
9.00	00900	HOUSEKEEPING	3	0	12	516	56	9.00
10.00	01000	DIETARY	6	0	30	1,295	359	10.00
11.00	01100	CAFETERIA	0	0	0	14	186	11.00
13.00	01300	NURSING ADMINISTRATION	4	0	14	590	30	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	6	244	433	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2	0	11	458	205	16.00
17.00	01700	SOCIAL SERVICE	2	0	7	304	15	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36	22	128	5,532	1,128	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1	6	14	586	419	50.00
53.00	05300	ANESTHESIOLOGY	0	2	0	11	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17	41	84	3,600	403	54.00
56.00	05600	RADIOISOTOPE	0	2	11	491	55	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8	12	504	0	58.00
60.00	06000	LABORATORY	15	63	108	4,652	195	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1	2	82	9	63.00
65.00	06500	RESPIRATORY THERAPY	6	5	22	944	20	65.00
66.00	06600	PHYSICAL THERAPY	9	12	32	1,400	147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3	5	199	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	7	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6	2	67	8	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7	22	44	1,891	81	73.00
76.00	03950	SLEEP LAB	0	2	5	199	143	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	39	0	185	7,975	841	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18	47	139	6,010	306	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	9	0	37	1,606	108	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	3	133	30	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	209	242	1,287	42,164	5,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9	0	0	1,000	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	251	194.03
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)	218	242	1,287	43,168	6,021	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part II Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	6,272					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	173	1,888				8.00
9.00	00900	HOUSEKEEPING	74	0	1,391			9.00
10.00	01000	DIETARY	470	0	108	6,117		10.00
11.00	01100	CAFETERIA	243	0	56	2,926	5,419	11.00
13.00	01300	NURSING ADMINISTRATION	39	0	9	0	73	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	567	0	131	0	2	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	62	0	118	16.00
17.00	01700	SOCIAL SERVICE	19	0	4	0	73	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,478	264	341	1,958	1,427	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	548	94	127	0	49	50.00
53.00	05300	ANESTHESIOLOGY	24	0	6	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	527	189	122	0	553	54.00
56.00	05600	RADIOISOTOPE	72	0	17	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	255	0	59	0	714	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12	0	3	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	26	0	6	0	216	65.00
66.00	06600	PHYSICAL THERAPY	193	566	44	0	290	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10	0	2	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105	0	24	0	158	73.00
76.00	03950	SLEEP LAB	187	0	43	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	997	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	400	756	92	0	550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	141	0	33	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	40	19	9	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,871	1,888	1,298	4,884	5,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	73	0	17	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	199	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	1,233	0	194.02
194.03	07953	KIDNEY CENTER	328	0	76	0	0	194.03
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)	6,272	1,888	1,391	6,117	5,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part II Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
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	1,082					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,027				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10	3,327			16.00
17.00	01700	SOCIAL SERVICE	32	1	0	614		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	597	305	295	568		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22	366	76	0		50.00
53.00	05300	ANESTHESIOLOGY	0	6	34	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	170	566	0		54.00
56.00	05600	RADIOISOTOPE	0	168	29	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	112	0		58.00
60.00	06000	LABORATORY	0	53	893	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	9	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	261	65	0		65.00
66.00	06600	PHYSICAL THERAPY	0	39	161	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25	43	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6	80	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32	3,263	295	0		73.00
76.00	03950	SLEEP LAB	0	10	29	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	409	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	243	466	639	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	152	128	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4	36	0	46		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,082	5,722	3,327	614	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	305	0	0		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	0	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0	0	0		194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,082	6,027	3,327	614	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B Part II | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	FOUNDATION BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMITTING					5.01
5.02	00511	HOSPITAL ONLY A&G					5.02
5.03	00560	SHARED ADMN & GENERAL					5.03
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	52,299	0	52,299		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	33,163	0	33,163		50.00
53.00	05300	ANESTHESIOLOGY	302	0	302		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,012	0	72,012		54.00
56.00	05600	RADIOISOTOPE	1,437	0	1,437		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	636	0	636		58.00
60.00	06000	LABORATORY	32,454	0	32,454		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	216	0	216		63.00
65.00	06500	RESPIRATORY THERAPY	4,626	0	4,626		65.00
66.00	06600	PHYSICAL THERAPY	5,936	0	5,936		66.00
67.00	06700	OCCUPATIONAL THERAPY	275	0	275		67.00
68.00	06800	SPEECH PATHOLOGY	8	0	8		68.00
69.00	06900	ELECTROCARDIOLOGY	266	0	266		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,785	0	6,785		73.00
76.00	03950	SLEEP LAB	7,881	0	7,881		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	24,551	0	24,551		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	14,378	0	14,378		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	3,370	0	3,370		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	647	0	647		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	261,242	0	261,242		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	695	0	695		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,513	0	1,513		192.00
194.00	07950	BOARD OF HEALTH	5,291	0	5,291		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0		194.01
194.02	07952	MOBILE MEALS	1,233	0	1,233		194.02
194.03	07953	KIDNEY CENTER	3,344	0	3,344		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	273,318	0	273,318		202.00

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		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	38,130					1.00
1.01	00101	FOUNDATION BLDG	0	12,473				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			157,769			2.00
4.00	00400	EMPLOYEE BENEFITS	129	0	0	3,163,720		4.00
5.01	00510	ADMITTING	140	0	0	68,279	9,724,357	5.01
5.02	00511	HOSPITAL ONLY A&G	756	0	0	122,894	0	5.02
5.03	00560	SHARED ADMN & GENERAL	3,935	5,019	21,041	204,045	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,858	114,367	0	6.00
7.00	00700	OPERATION OF PLANT	2,801	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	838	0	0	1,508	0	8.00
9.00	00900	HOUSEKEEPING	357	0	112	45,584	0	9.00
10.00	01000	DIETARY	2,274	0	0	88,217	0	10.00
11.00	01100	CAFETERIA	1,178	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	191	0	0	59,222	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,744	0	0	672	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,296	0	0	23,767	0	16.00
17.00	01700	SOCIAL SERVICE	93	0	0	30,948	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,147	0	23,183	525,328	861,562	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,655	0	23,395	15,866	223,623	50.00
53.00	05300	ANESTHESIOLOGY	118	0	0	0	99,524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,552	0	54,508	241,273	1,656,347	54.00
56.00	05600	RADIOISOTOPE	350	0	0	0	84,590	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	328,661	58.00
60.00	06000	LABORATORY	1,237	0	20,726	211,344	2,601,633	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	58	0	0	2,256	27,772	63.00
65.00	06500	RESPIRATORY THERAPY	124	0	2,525	80,324	190,316	65.00
66.00	06600	PHYSICAL THERAPY	933	0	1,299	133,095	472,137	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	125,156	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,664	68.00
69.00	06900	ELECTROCARDIOLOGY	50	0	0	0	233,617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510	0	0	108,514	862,477	73.00
76.00	03950	SLEEP LAB	907	0	5,083	0	84,786	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,326	766	563,516	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,937	0	1,273	262,009	1,868,492	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	683	0	0	131,849	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	193	0	0	3,796	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,186	10,345	157,769	3,038,673	9,724,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	125,047	0	192.00
194.00	07950	BOARD OF HEALTH	0	2,128	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	1,589	0	0	0	0	194.03
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)	64,531	31,011	177,776	856,584	94,565	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.692394	2.486250	1.126812	0.270752	0.009725	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				218	242	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000069	0.000025	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B-1 | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	Reconciliation	HOSPITAL ONLY A&G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G	-339,393	7,646,999				5.02
5.03	00560	SHARED ADMN & GENERAL	0	1,822,574	-1,903,461	6,227,833		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	224,932	0	234,915	38,141	6.00
7.00	00700	OPERATION OF PLANT	0	147,079	0	153,607	2,801	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,205	0	23,191	838	8.00
9.00	00900	HOUSEKEEPING	0	71,340	0	74,506	357	9.00
10.00	01000	DIETARY	0	178,901	0	186,841	2,274	10.00
11.00	01100	CAFETERIA	0	1,994	0	2,082	1,178	11.00
13.00	01300	NURSING ADMINISTRATION	0	81,450	0	85,065	191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,714	0	35,210	2,744	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,215	0	66,021	1,296	16.00
17.00	01700	SOCIAL SERVICE	0	41,940	0	43,801	93	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	764,209	0	798,127	7,147	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,952	0	84,545	2,655	50.00
53.00	05300	ANESTHESIOLOGY	0	1,506	0	1,573	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,371	0	519,446	2,552	54.00
56.00	05600	RADIOISOTOPE	0	67,831	0	70,842	350	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	69,646	0	72,737	0	58.00
60.00	06000	LABORATORY	0	642,698	0	671,223	1,237	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,370	0	11,875	58	63.00
65.00	06500	RESPIRATORY THERAPY	0	130,431	0	136,220	124	65.00
66.00	06600	PHYSICAL THERAPY	0	193,338	0	201,919	933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,497	0	28,717	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	936	0	978	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,248	0	9,658	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	261,183	0	272,775	510	73.00
76.00	03950	SLEEP LAB	0	27,522	0	28,744	907	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,101,445	0	1,150,330	5,326	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	830,201	0	867,048	1,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	221,855	0	231,702	683	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	18,416	0	19,233	193	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-339,393	7,646,999	-1,903,461	6,082,931	36,552	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-601	0	0	601	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-144,301	0	0	144,301	0	192.00
194.00	07950	BOARD OF HEALTH	-5,291	0	-5,291	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	-2,689	0	-2,689	0	1,589	194.03
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)		339,393		1,903,461	306,714	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.044383		0.305638	8.041583	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,287		43,168	6,021	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000168		0.006931	0.157862	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B-1 | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	30,369					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	838	16,234				8.00
9.00	00900	HOUSEKEEPING	357	0	29,174			9.00
10.00	01000	DIETARY	2,274	0	2,274	10,743		10.00
11.00	01100	CAFETERIA	1,178	0	1,178	5,139	7,592	11.00
13.00	01300	NURSING ADMINISTRATION	191	0	191	0	102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,744	0	2,744	0	3	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,296	0	1,296	0	166	16.00
17.00	01700	SOCIAL SERVICE	93	0	93	0	102	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,147	2,273	7,147	3,439	2,000	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,655	812	2,655	0	68	50.00
53.00	05300	ANESTHESIOLOGY	118	0	118	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,552	1,623	2,552	0	775	54.00
56.00	05600	RADIOISOTOPE	350	0	350	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,237	0	1,237	0	1,000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	58	0	58	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	124	0	124	0	303	65.00
66.00	06600	PHYSICAL THERAPY	933	4,870	933	0	406	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	50	0	50	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510	0	510	0	221	73.00
76.00	03950	SLEEP LAB	907	0	907	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,397	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,937	6,494	1,937	0	770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	683	0	683	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	193	162	193	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,425	16,234	27,230	8,578	7,313	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	0	355	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	279	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	2,165	0	194.02
194.03	07953	KIDNEY CENTER	1,589	0	1,589	0	0	194.03
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)	223,079	43,174	102,771	286,949	162,258	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.345616	2.659480	3.522691	26.710323	21.372234	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,272	1,888	1,391	6,117	5,419	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.206526	0.116299	0.047679	0.569394	0.713778	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet B-1 | Date/Time Prepared: 6/25/2013 9:22 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMITTING						5.01
5.02	00511	HOSPITAL ONLY A&G						5.02
5.03	00560	SHARED ADMN & GENERAL						5.03
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	41,578					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	333,249				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	555	9,724,357			16.00
17.00	01700	SOCIAL SERVICE	1,232	72	0	146		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,948	16,880	861,562	135		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	830	20,261	223,623	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	338	99,524	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,407	1,656,347	0	0	54.00
56.00	05600	RADIOISOTOPE	0	9,305	84,590	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	328,661	0	0	58.00
60.00	06000	LABORATORY	0	2,915	2,601,633	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	27,772	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2	14,431	190,316	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,178	472,137	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,406	125,156	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,664	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	312	233,617	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,232	180,333	862,477	0	0	73.00
76.00	03950	SLEEP LAB	0	579	84,786	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	22,612	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,337	25,746	1,868,492	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,827	7,071	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	170	2,003	0	11	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,578	316,404	9,724,357	146	0	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	16,845	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
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)	116,856	97,924	114,418	64,611	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.810525	0.293846	0.011766	442.541096	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,082	6,027	3,327	614	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.026023	0.018086	0.000342	4.205479	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet C Part I Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,457,194		1,457,194	0	0	683,098	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	175,121		175,121	0	0	442	50.00
53.00	05300	ANESTHESIOLOGY	5,556		5,556	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	769,598		769,598	0	0	56,154	54.00
56.00	05600	RADIOISOTOPE	102,842		102,842	0	0	1,706	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98,835		98,835	0	0	8,661	58.00
60.00	06000	LABORATORY	952,606		952,606	0	0	187,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,927		16,927	0	0	7,848	63.00
65.00	06500	RESPIRATORY THERAPY	193,160	0	193,160	0	0	140,395	65.00
66.00	06600	PHYSICAL THERAPY	309,100	0	309,100	0	0	79,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,380	0	39,380	0	0	56,309	67.00
68.00	06800	SPEECH PATHOLOGY	1,320	0	1,320	0	0	1,221	68.00
69.00	06900	ELECTROCARDIOLOGY	16,396		16,396	0	0	17,948	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,114		437,114	0	0	376,949	73.00
76.00	03950	SLEEP LAB	55,848		55,848	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,581,244		1,581,244	0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	0	90.00
91.00	09100	EMERGENCY	1,258,199		1,258,199	0	0	34,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	346,509		346,509		0	2,367	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	333,889		333,889		0	0	101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	35,127		35,127		0	833	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	0	117.00
200.00		Subtotal (see instructions)	8,185,965	0	8,185,965	0	0	1,655,470	200.00
201.00		Less Observation Beds	346,509		346,509		0		201.00
202.00		Total (see instructions)	7,839,456	0	7,839,456	0	0	1,655,470	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		683,098					30.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	223,181	223,623	0.783108	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	99,524	99,524	0.055826	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,600,193	1,656,347	0.464636	0.000000	0.000000		54.00
56.00	05600	RADIOISOTOPE	82,884	84,590	1.215770	0.000000	0.000000		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	320,000	328,661	0.300720	0.000000	0.000000		58.00
60.00	06000	LABORATORY	2,414,116	2,601,633	0.366157	0.000000	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	19,924	27,772	0.609499	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	49,921	190,316	1.014944	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	392,251	472,137	0.654683	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	68,847	125,156	0.314647	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,443	3,664	0.360262	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	215,668	233,616	0.070184	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet C Part I Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	485,528	862,477	0.506812	0.000000	0.000000		73.00
76.00	03950	SLEEP LAB	84,786	84,786	0.658694	0.000000	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,119,084	2,119,084					88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	1,834,356	1,868,492	0.673377	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,097	178,464	1.941618	0.000000	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	338,878	338,878					101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	94,628	95,461					116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0					117.00
200.00		Subtotal (see instructions)	10,622,309	12,277,779					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	10,622,309	12,277,779					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet C Part I Date/Time Prepared: 6/25/2013 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,457,194		1,457,194	0	0	683,098	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	175,121		175,121	0	0	442	50.00
53.00	05300	ANESTHESIOLOGY	5,556		5,556	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	769,598		769,598	0	0	56,154	54.00
56.00	05600	RADIOISOTOPE	102,842		102,842	0	0	1,706	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	98,835		98,835	0	0	8,661	58.00
60.00	06000	LABORATORY	952,606		952,606	0	0	187,517	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,927		16,927	0	0	7,848	63.00
65.00	06500	RESPIRATORY THERAPY	193,160	0	193,160	0	0	140,395	65.00
66.00	06600	PHYSICAL THERAPY	309,100	0	309,100	0	0	79,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,380	0	39,380	0	0	56,309	67.00
68.00	06800	SPEECH PATHOLOGY	1,320	0	1,320	0	0	1,221	68.00
69.00	06900	ELECTROCARDIOLOGY	16,396		16,396	0	0	17,948	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	437,114		437,114	0	0	376,949	73.00
76.00	03950	SLEEP LAB	55,848		55,848	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,581,244		1,581,244	0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	0	90.00
91.00	09100	EMERGENCY	1,258,199		1,258,199	0	0	34,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	346,509		346,509		0	2,367	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	333,889		333,889		0	0	101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	35,127		35,127		0	833	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	0	117.00
200.00		Subtotal (see instructions)	8,185,965	0	8,185,965	0	0	1,655,470	200.00
201.00		Less Observation Beds	346,509		346,509		0		201.00
202.00		Total (see instructions)	7,839,456	0	7,839,456	0	0	1,655,470	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		683,098					30.00
41.00	04100	SUBPROVIDER - IRF		0					41.00
42.00	04200	SUBPROVIDER		0					42.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	223,181	223,623	0.783108	0.000000	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	99,524	99,524	0.055826	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,600,193	1,656,347	0.464636	0.000000	0.000000		54.00
56.00	05600	RADIOISOTOPE	82,884	84,590	1.215770	0.000000	0.000000		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	320,000	328,661	0.300720	0.000000	0.000000		58.00
60.00	06000	LABORATORY	2,414,116	2,601,633	0.366157	0.000000	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	19,924	27,772	0.609499	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	49,921	190,316	1.014944	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	392,251	472,137	0.654683	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	68,847	125,156	0.314647	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,443	3,664	0.360262	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	215,668	233,616	0.070184	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet C Part I Date/Time Prepared: 6/25/2013 9:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	485,528	862,477	0.506812	0.000000	0.000000		73.00
76.00	03950	SLEEP LAB	84,786	84,786	0.658694	0.000000	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,119,084	2,119,084	0.746192	0.000000	0.000000		88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
91.00	09100	EMERGENCY	1,834,356	1,868,492	0.673377	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,097	178,464	1.941618	0.000000	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	338,878	338,878					101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	94,628	95,461					116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0					117.00
200.00		Subtotal (see instructions)	10,622,309	12,277,779					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	10,622,309	12,277,779					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part II Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,163	223,623	0.148299	442	66	50.00
53.00	05300	ANESTHESIOLOGY	302	99,524	0.003034	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,012	1,656,347	0.043476	26,320	1,144	54.00
56.00	05600	RADIOISOTOPE	1,437	84,590	0.016988	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	636	328,661	0.001935	8,661	17	58.00
60.00	06000	LABORATORY	32,454	2,601,633	0.012474	94,439	1,178	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	216	27,772	0.007778	6,031	47	63.00
65.00	06500	RESPIRATORY THERAPY	4,626	190,316	0.024307	77,061	1,873	65.00
66.00	06600	PHYSICAL THERAPY	5,936	472,137	0.012573	10,592	133	66.00
67.00	06700	OCCUPATIONAL THERAPY	275	125,156	0.002197	10,752	24	67.00
68.00	06800	SPEECH PATHOLOGY	8	3,664	0.002183	732	2	68.00
69.00	06900	ELECTROCARDIOLOGY	266	233,616	0.001139	13,716	16	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,785	862,477	0.007867	173,231	1,363	73.00
76.00	03950	SLEEP LAB	7,881	84,786	0.092952	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,551	2,119,084	0.011586	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	14,378	1,868,492	0.007695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	178,464	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	204,926	11,160,342		421,977	5,863	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part IV Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part IV Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		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	223,623	0.000000	0.000000	442	50.00
53.00	05300	ANESTHESIOLOGY	0	99,524	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,656,347	0.000000	0.000000	26,320	54.00
56.00	05600	RADIOISOTOPE	0	84,590	0.000000	0.000000	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	328,661	0.000000	0.000000	8,661	58.00
60.00	06000	LABORATORY	0	2,601,633	0.000000	0.000000	94,439	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	27,772	0.000000	0.000000	6,031	63.00
65.00	06500	RESPIRATORY THERAPY	0	190,316	0.000000	0.000000	77,061	65.00
66.00	06600	PHYSICAL THERAPY	0	472,137	0.000000	0.000000	10,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	125,156	0.000000	0.000000	10,752	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,664	0.000000	0.000000	732	68.00
69.00	06900	ELECTROCARDIOLOGY	0	233,616	0.000000	0.000000	13,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	862,477	0.000000	0.000000	173,231	73.00
76.00	03950	SLEEP LAB	0	84,786	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,119,084	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,868,492	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	178,464	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	11,160,342			421,977	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet D Part IV Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Hospital	Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part V Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.783108	0	77,254	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055826	0	22,333	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464636	0	565,233	0	0	54.00
56.00	05600	RADIOISOTOPE	1.215770	0	9,216	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.300720	0	72,979	0	0	58.00
60.00	06000	LABORATORY	0.366157	0	1,089,624	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.609499	0	12,326	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1.014944	0	29,725	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.654683	0	187,547	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314647	0	33,963	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.360262	0	2,199	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070184	0	99,101	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.506812	0	277,481	0	0	73.00
76.00	03950	SLEEP LAB	0.658694	0	18,622	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.673377	0	652,571	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.941618	0	99,888	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	3,250,062	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	3,250,062	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part V Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	60,498	0		50.00
53.00	05300	ANESTHESIOLOGY	1,247	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,628	0		54.00
56.00	05600	RADIOISOTOPE	11,205	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,946	0		58.00
60.00	06000	LABORATORY	398,973	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,513	0		63.00
65.00	06500	RESPIRATORY THERAPY	30,169	0		65.00
66.00	06600	PHYSICAL THERAPY	122,784	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,686	0		67.00
68.00	06800	SPEECH PATHOLOGY	792	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,955	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,631	0		73.00
76.00	03950	SLEEP LAB	12,266	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	439,426	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	193,944	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
200.00		Subtotal (see instructions)	1,721,663	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,721,663	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part V Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.783108	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055826	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464636	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	1.215770	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.300720	0	0	0	0	58.00
60.00	06000	LABORATORY	0.366157	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.609499	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1.014944	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.654683	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314647	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.360262	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070184	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.506812	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.658694	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.673377	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.941618	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D Part V | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet D-1 Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,076	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	644	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)	389	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	347	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)	81	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	3	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)	1	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	300	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)	287	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)	67	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	122.07	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,457,194	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)	366	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)	127	25.00
26.00	Total swing-bed cost (see instructions)	582,085	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	875,109	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	421,051	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	421,051	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.078392	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,082.39	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)	875,109	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)	1,358.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	407,658	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)	407,658	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D-1 | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

	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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	230,989	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	638,647	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	389,993	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	91,044	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	481,037	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)	255	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,358.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	346,509	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D-1 | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D-3 | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		302,330		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.783108	442	346	50.00
53.00	05300	ANESTHESIOLOGY	0.055826	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464636	26,320	12,229	54.00
56.00	05600	RADIOISOTOPE	1.215770	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.300720	8,661	2,605	58.00
60.00	06000	LABORATORY	0.366157	94,439	34,580	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.609499	6,031	3,676	63.00
65.00	06500	RESPIRATORY THERAPY	1.014944	77,061	78,213	65.00
66.00	06600	PHYSICAL THERAPY	0.654683	10,592	6,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314647	10,752	3,383	67.00
68.00	06800	SPEECH PATHOLOGY	0.360262	732	264	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070184	13,716	963	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.506812	173,231	87,796	73.00
76.00	03950	SLEEP LAB	0.658694	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.673377	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.941618	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		421,977	230,989	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		421,977		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet D-3 | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.783108	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.055826	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464636	4,761	2,212	54.00
56.00	05600	RADIOISOTOPE	1.215770	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.300720	0	0	58.00
60.00	06000	LABORATORY	0.366157	43,773	16,028	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.609499	606	369	63.00
65.00	06500	RESPIRATORY THERAPY	1.014944	35,163	35,688	65.00
66.00	06600	PHYSICAL THERAPY	0.654683	55,749	36,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314647	36,800	11,579	67.00
68.00	06800	SPEECH PATHOLOGY	0.360262	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070184	486	34	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.506812	97,030	49,176	73.00
76.00	03950	SLEEP LAB	0.658694	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.673377	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.941618	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		274,368	151,584	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		274,368		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet E Part B Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,721,663	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,721,663	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,738,880	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	9,140	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	427,296	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)	1,302,444	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)	1,302,444	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,302,444	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)	67,616	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	67,616	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,616	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,370,060	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,370,060	40.00
41.00	Interim payments	1,211,276	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	158,784	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		454,599		1,158,500	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	01/23/2013	77,422	01/23/2013	52,776	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)		77,422		52,776	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)		532,021		1,211,276	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		46,118		158,784	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		578,139		1,370,060	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		500,831		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/23/2013	108,197		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)		108,197		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)		609,028		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		24,280		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		633,308		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141304 Component CCN: 14Z304	Period: From 07/01/2012 To 01/31/2013	Worksheet E-2 Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	485,847	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	153,100	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	354	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	638,947	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	638,947	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	638,947	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,639	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	633,308	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	633,308	0	19.00
20.00	Interim payments	609,028	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	24,280	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2012 To 01/31/2013	Worksheet E-3 Part V Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	638,647	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	638,647	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	645,033	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	645,033	19.00
20.00	Deductibles (exclude professional component)	82,717	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	562,316	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	562,316	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,823	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,823	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,823	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	578,139	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	578,139	30.00
31.00	Interim payments	532,021	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	46,118	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet G | Date/Time Prepared: 6/25/2013 9:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,798,877	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,583,365	0	0	0	4.00
5.00	Other receivable	251,040	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	246,896	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	69,272	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)	4,949,450	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	43,583	0	0	0	12.00
13.00	Land improvements	24,966	0	0	0	13.00
14.00	Accumulated depreciation	-11,025	0	0	0	14.00
15.00	Buildings	4,609,531	0	0	0	15.00
16.00	Accumulated depreciation	-3,216,248	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,861,104	0	0	0	23.00
24.00	Accumulated depreciation	-4,089,519	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)	3,222,392	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,390,429	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	37,542	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,427,971	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,599,813	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	590,841	0	0	0	37.00
38.00	Salaries, wages, and fees payable	606,152	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,577,522	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,028,496	0	0	0	43.00
44.00	Other current liabilities	457,376	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,260,387	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,260,387	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,339,426				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)	5,339,426	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,599,813	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet G-1 | Date/Time Prepared: 6/25/2013 9:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,939,738		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		399,688				2.00
3.00	Total (sum of line 1 and line 2)		5,339,426		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,339,426		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)		5,339,426		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			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: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/25/2013 9:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	421,051		421,051	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	262,047		262,047	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)	683,098		683,098	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	683,098		683,098	17.00
18.00	Ancillary services	935,035	6,059,265	6,994,300	18.00
19.00	Outpatient services	36,504	2,014,277	2,050,781	19.00
20.00	RURAL HEALTH CLINIC	0	2,119,084	2,119,084	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		338,878	338,878	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	5,461	90,000	95,461	26.00
27.00	PROFESSIONAL FEES	11,358	1,168,371	1,179,729	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,671,456	11,789,875	13,461,331	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		7,866,190		29.00
30.00	BAD DEBT EXPENSE	432,899			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)		432,899		36.00
37.00	MCNH LEASED EMPLOYEES	25,822			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)		25,822		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		8,273,267		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet G-3 | Date/Time Prepared: 6/25/2013 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,461,331	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,767,183	2.00
3.00	Net patient revenues (line 1 minus line 2)	7,694,148	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	8,273,267	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-579,119	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	5,779	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	565	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	29,429	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	252	16.00
17.00	Revenue from sale of drugs to other than patients	124,084	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	10,731	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - TAX REVENUE	337,772	24.00
24.01	OTHER - OTHER REVENUE	28,654	24.01
24.02	OTHER - FARM INCOME	83,886	24.02
24.03	GRANTS	357,643	24.03
25.00	Total other income (sum of lines 6-24)	978,795	25.00
26.00	Total (line 5 plus line 25)	399,676	26.00
27.00	ROUNDING	-12	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-12	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	399,688	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H

HHA CCN: 147462 | Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 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	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	32,375	2,938	21,392	3,127	12,865	72,697	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	84,201	7,641	0	0	0	91,842	6.00
7.00	Physical Therapy	9,794	889	215	2,228	0	13,126	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	20,463	1,857	0	0	0	22,320	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	146,833	13,325	21,607	5,355	12,865	199,985	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	-14,984	57,713	0	57,713			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	91,842	0	91,842			6.00
7.00	Physical Therapy	0	13,126	0	13,126			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	22,320	0	22,320			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-14,984	185,001	0	185,001			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.
H:\ACCT\REIMB\Mercer County Cost Reports\FPE 01312013 (Terminating CR)\MCR Files\1413042013term.mcrx

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-1 Part I Date/Time Prepared: 6/25/2013 9:22 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		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		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	57,713	0	0	0	0	57,713	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	91,842	0	0	0	0	91,842	6.00
7.00	Physical Therapy	13,126	0	0	0	0	13,126	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	22,320	0	0	0	0	22,320	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	185,001	0	0	0	0	185,001	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	57,713			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	41,642	133,484		6.00
7.00	Physical Therapy	5,951	19,077		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	10,120	32,440		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		185,001		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-1 Part II Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	683				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	683		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	683	0	683	0	-57,713	127,288	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	91,842	6.00
7.00	Physical Therapy	0	0	0	0	0	13,126	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	22,320	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	683	0	683	0	-57,713	127,288	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		57,713	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.453405	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 | HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS FOUNDATION BLDG	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	ADMITTING	
		0	1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	0	1,156	0	0	35,698	0	1.00
2.00	Skilled Nursing Care	133,484	0	0	0	0	0	2.00
3.00	Physical Therapy	19,077	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	32,440	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)	185,001	1,156	0	0	35,698	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	HOSPITAL ONLY A&G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5A.01	5.02	5A.02	5.03	6.00	7.00	
1.00	Administrative and General	36,854	1,636	38,490	11,764	5,492	5,017	1.00
2.00	Skilled Nursing Care	133,484	5,924	139,408	42,608	0	0	2.00
3.00	Physical Therapy	19,077	847	19,924	6,090	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	32,440	1,440	33,880	10,355	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)	221,855	9,847	231,702	70,817	5,492	5,017	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | PPS

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,406	0	0	16,377	2,078	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	2,406	0	0	16,377	2,078	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	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	81,624	0	81,624	1.00
2.00	Skilled Nursing Care	0	0	0	182,016	0	182,016	2.00
3.00	Physical Therapy	0	0	0	26,014	0	26,014	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	44,235	0	44,235	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	333,889	0	333,889	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.
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-2 Part I Date/Time Prepared: 6/25/2013 9:22 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs			
		27.00	28.00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	58,894	240,910			2.00
3.00	Physical Therapy	8,417	34,431			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	14,313	58,548			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	81,624	333,889			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.	0.323565				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: 141304 HHA CCN: 147462

Period: From 07/01/2012 To 01/31/2013

Worksheet H-2 Part II Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS FOUNDATION BLDG (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
		1.00	1.01	2.00	4.00	5.01	5A.02	
1.00	Administrative and General	683	0	0	131,849	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)	683	0	0	131,849	0		20.00
21.00	Total cost to be allocated	1,156	0	0	35,698	0		21.00
22.00	Unit cost multiplier	1.692533	0.000000	0.000000	0.270749	0.000000		22.00

	Cost Center Description	HOSPITAL ONLY A&G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5A.03	5.03	6.00	7.00	8.00	
1.00	Administrative and General	36,854	0	38,490	683	683	0	1.00
2.00	Skilled Nursing Care	133,484	0	139,408	0	0	0	2.00
3.00	Physical Therapy	19,077	0	19,924	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	32,440	0	33,880	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)	221,855		231,702	683	683	0	20.00
21.00	Total cost to be allocated	9,847		70,817	5,492	5,017	0	21.00
22.00	Unit cost multiplier	0.044385		0.305638	8.040996	7.345534	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141304 HHA CCN: 147462

Period: From 07/01/2012 To 01/31/2013

Worksheet H-2 Part II Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I

PPS

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	683	0	0	5,827	7,071	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)	683	0	0	5,827	7,071	0	20.00
21.00	Total cost to be allocated	2,406	0	0	16,377	2,078	0	21.00
22.00	Unit cost multiplier	3.522694	0.000000	0.000000	2.810537	0.293876	0.000000	22.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141304 | HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 6/25/2013 9:22 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	240,910		240,910	697	345.64	1.00
2.00	Physical Therapy	3.00	34,431	0	34,431	126	273.26	2.00
3.00	Occupational Therapy	4.00	0	0	0	42	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	1	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	58,548		58,548	556	105.30	6.00
7.00	Total (sum of lines 1-6)		333,889	0	333,889	1,422		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	167	289			8.00
9.00	Physical Therapy		19340	51	48			9.00
10.00	Occupational Therapy		19340	21	17			10.00
11.00	Speech Pathology		19340	0	1			11.00
12.00	Medical Social Services		19340	0	0			12.00
13.00	Home Health Aide		19340	162	295			13.00
14.00	Total (sum of lines 8-13)			401	650			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	3,456	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	167	289		57,722	99,890		1.00
2.00	Physical Therapy	51	48		13,936	13,116		2.00
3.00	Occupational Therapy	21	17		0	0		3.00
4.00	Speech Pathology	0	1		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	162	295		17,059	31,064		6.00
7.00	Total (sum of lines 1-6)	401	650		88,717	144,070		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-3 Part I Date/Time Prepared: 6/25/2013 9:22 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	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	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 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	157,612	1.00
2.00	Physical Therapy	27,052	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	48,123	6.00
7.00	Total (sum of lines 1-6)	232,787	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-3 Part II Date/Time Prepared: 6/25/2013 9:22 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.654683	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.314647	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.360262	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.000000	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.506812	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141304 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-4 Part I-II
HHA CCN: 147462 | Date/Time Prepared: 6/25/2013 9:22 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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	1.00
2.00	Total charges	69,926	117,242	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	69,926	117,242	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	69,926	117,242	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	51,906	71,866	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	1,779	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,019	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	51,906	74,664	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	51,906	74,664	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	51,906	74,664	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-4 Part I-II Date/Time Prepared: 6/25/2013 9:22 am

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		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	51,906	74,664	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	51,906	74,664	31.00
32.00	Interim payments (see instructions)	51,906	74,664	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 141304 HHA CCN: 147462 | Period: From 07/01/2012 To 01/31/2013 | Worksheet H-5 | Date/Time Prepared: 6/25/2013 9:22 am

Home Health Agency I | 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		51,906		74,664	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)		51,906		74,664	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		51,906		74,664	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141304 HHA CCN: 147462	Period: From 07/01/2012 To 01/31/2013	Worksheet H-5 Date/Time Prepared: 6/25/2013 9:22 am
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					Contractor Number	Date (Mo/Day/Yr)	
			0		1.00	2.00	
8.00	Name of Contractor						8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	3,796	271	517	403	4,399	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	5,672	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	2,003	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	3,796	271	517	403	12,074	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2012 To 01/31/2013 | Worksheet K | Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	9,386	0	9,386	0	9,386	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	5,672	0	5,672	0	5,672	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	2,003	0	2,003	0	2,003	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	17,061	0	17,061	0	17,061	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-1

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	187	2,808	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	187	2,808	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-1

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	801	3,796		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	801	3,796		39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-2

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	13	201	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	13	201	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-2

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	57	271		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	57	271		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2012 To 01/31/2013 | Worksheet K-3 Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	403	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	403	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-3

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	403		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	403		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-4 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	9,386	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	5,672	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	2,003	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	17,061	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-4 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0	0			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	9,386	0	9,386		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	5,672	0	5,672		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	2,003	0	2,003		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	17,061		17,061		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2012 To 01/31/2013 | Worksheet K-4 Part II Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 Hospice CCN: 141593 | Period: From 07/01/2012 To 01/31/2013 | Worksheet K-4 Part II Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	0	17,061		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	9,386		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	5,672		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	2,003		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0		39.00
40.00	Unit Cost Multiplier		0.000000		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		327	0	0	1,028	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	9,386	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	5,672	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	2,003	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	17,061	327	0	0	1,028	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	ADMITTING	Subtotal	HOSPITAL ONLY A&G	Subtotal	SHARED ADMN & GENERAL	
		5.01	5A.01	5.02	5A.02	5.03	
1.00	Administrative and General	0	1,355	60	1,415	432	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	9,386	416	9,802	2,997	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	5,672	252	5,924	1,810	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	2,003	89	2,092	639	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	18,416	817	19,233	5,878	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000		0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	1,552	1,418	431	680	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,552	1,418	431	680	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
1.00	Administrative and General	0	478	589	0	4,868	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	478	589	0	4,868	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	
		19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	11,863				1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	12,799	0	12,799	6,526	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	7,734	0	7,734	3,944	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	2,731	0	2,731	1,393	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	35,127	0	35,127		34.00
35.00	Unit Cost Multiplier (see instructions)					0.509930	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part I Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	Total Hospice Costs (cols. 26 ± 27)		
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	19,325		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	11,678		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	4,124		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	35,127		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

Period:
From 07/01/2012
To 01/31/2013

Worksheet K-5
Part II
Date/Time Prepared:
6/25/2013 9:22 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	
		1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	48	0	0	26,426	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	48	0	0	26,426	0	34.00
35.00	Total cost to be allocated	327	0	0	1,028	0	35.00
36.00	Unit Cost Multiplier (see instructions)	6.812500	0.000000	0.000000	0.038901	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

Period:
From 07/01/2012
To 01/31/2013

Worksheet K-5
Part II
Date/Time Prepared:
6/25/2013 9:22 am

Hospice I

	Cost Center Description	Reconciliation	HOSPITAL ONLY A&G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	6.00	
1.00	Administrative and General	0	1,355	0	1,415	48	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	9,386	0	9,802	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	5,672	0	5,924	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	2,003	0	2,092	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		18,416		19,233	48	34.00
35.00	Total cost to be allocated		817		5,878	1,552	35.00
36.00	Unit Cost Multiplier (see instructions)		0.044364		0.305621	32.333333	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

Period:
From 07/01/2012
To 01/31/2013

Worksheet K-5
Part II
Date/Time Prepared:
6/25/2013 9:22 am

Hospice I

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	48	116	48	0	2	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	48	116	48	0	2	34.00
35.00	Total cost to be allocated	1,418	431	680	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	29.541667	3.715517	14.166667	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141304
Hospice CCN: 141593

Period:
From 07/01/2012
To 01/31/2013

Worksheet K-5
Part II
Date/Time Prepared:
6/25/2013 9:22 am

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		13.00	14.00	16.00	17.00	19.00	
1.00	Administrative and General	889	6,346	0	11	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	889	6,346	0	11	0	34.00
35.00	Total cost to be allocated	478	589	0	4,868	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.537683	0.092814	0.000000	442.545455	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-5 Part III Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.654683	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.314647	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.360262	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.506812	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.366157	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTE	93.00	0.000000	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	SLEEP LAB	76.00	0.658694	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 141304 Hospice CCN: 141593

Period: From 07/01/2012 To 01/31/2013

Worksheet K-6

Date/Time Prepared: 6/25/2013 9:22 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				35,127	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				108	2.00
3.00	Average cost per diem (line 1 divided by line 2)				325.25	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	99				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	32,200				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		3			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		976			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			6		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			1,952		13.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2012 To 01/31/2013 | Worksheet M-1 Date/Time Prepared: 6/25/2013 9:22 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	253,289	214,717	468,006	0	468,006	1.00
2.00	Physician Assistant	110,322	6,074	116,396	0	116,396	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	140,555	7,739	148,294	-52,540	95,754	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	24,580	1,353	25,933	0	25,933	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)	528,746	229,883	758,629	-52,540	706,089	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	84,156	84,156	0	84,156	13.00
14.00	Subtotal (sum of lines 11-13)	0	84,156	84,156	0	84,156	14.00
15.00	Medical Supplies	0	18,739	18,739	0	18,739	15.00
16.00	Transportation (Health Care Staff)	0	9,085	9,085	0	9,085	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	-105,332	-105,332	18.00
19.00	Other Health Care Costs	0	1,893	1,893	0	1,893	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	29,717	29,717	-105,332	-75,615	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	528,746	343,756	872,502	-157,872	714,630	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
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	44,160	44,160	-36,156	8,004	29.00
30.00	Administrative Costs	87,312	123,974	211,286	0	211,286	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	87,312	168,134	255,446	-36,156	219,290	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	616,058	511,890	1,127,948	-194,028	933,920	32.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2012 To 01/31/2013 | Worksheet M-1 | Date/Time Prepared: 6/25/2013 9:22 am

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	-21,072	446,934		1.00
2.00	Physician Assistant	0	116,396		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	95,754		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	25,933		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)	-21,072	685,017		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	84,156		13.00
14.00	Subtotal (sum of lines 11-13)	0	84,156		14.00
15.00	Medical Supplies	0	18,739		15.00
16.00	Transportation (Health Care Staff)	0	9,085		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	-105,332		18.00
19.00	Other Health Care Costs	0	1,893		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	-75,615		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,072	693,558		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
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	8,004		29.00
30.00	Administrative Costs	21,919	233,205		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	21,919	241,209		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	847	934,767		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2012 To 01/31/2013 | Worksheet M-2 | Date/Time Prepared: 6/25/2013 9:22 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.54	5,742	4,200	6,468		1.00
2.00	Physician Assistant	0.47	1,913	2,100	987		2.00
3.00	Nurse Practitioner	0.47	1,027	2,100	987		3.00
4.00	Subtotal (sum of lines 1-3)	2.48	8,682		8,442	8,682	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)	2.48	8,682			8,682	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)					693,558	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)					693,558	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)					241,209	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					646,477	15.00
16.00	Total overhead (sum of lines 14 and 15)					887,686	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					887,686	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					887,686	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,581,244	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2012 To 01/31/2013	Worksheet M-3 Date/Time Prepared: 6/25/2013 9:22 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,581,244	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,581,244	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		8,682	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)		8,682	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.13	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	182.13	182.13	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,649	264	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	300,332	48,082	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		348,414	16.00
16.01	Total program charges (see instructions)(from contractor's records)		460,061	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.)		257,880	16.04
16.05	Total program cost (see instructions)		257,880	16.05
17.00	Primary payer amounts		476	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		26,064	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		86,800	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		257,404	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		257,404	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		257,404	26.00
27.00	Interim payments		230,123	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		27,281	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2012 To 01/31/2013 | Worksheet M-4 | Date/Time Prepared: 6/25/2013 9:22 am

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	685,017	685,017	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	0	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	693,558	693,558	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	887,686	887,686	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		0	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)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2012 To 01/31/2013	Worksheet M-5 Date/Time Prepared: 6/25/2013 9:22 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		205,520	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		01/23/2013	24,603	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)		24,603	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		230,123	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		27,281	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		257,404	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00