

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/30/2013 1:36 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2013 Time: 1:36 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JASPER COUNTY HOSPITAL (151324) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-331,966	-513,101	0	-56,771	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	67,717	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	3,047	0	0	10.00
10.03 RURAL HEALTH CLINIC IV IV	0	0	7,437	0	0	10.03
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-264,249	-502,617	0	-56,771	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: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 1:34 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 47978-		4.00 County: JASPER		1.00
1.00	Street: 1104 EAST GRACE STREET	State: IN		Zip Code: 47978-		County: JASPER		2.00
2.00	City: RENSSELAER							

	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	JASPER COUNTY HOSPITAL	151324	99915	1	02/03/2005	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	JASPER COUNTY HOSPITAL	152324	99915		12/31/2005	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 OLTG									11.00
12.00	Hospital-Based HHA	JASPER COUNTY HOSPITAL	157149	99915		05/13/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	JASPER COUNTY HOSPITAL	151519	99915		03/12/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.03	Hospital-Based Health Clinic - RHC IV	BROOK	158502	99915		01/01/2005	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:	
						1.00	2.00	

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	9		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 days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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	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: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 1:34 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 1:34 pm		
		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.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	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)	N			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.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 1:34 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	54,831	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 1:34 pm		
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 1:34 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/10/2013	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: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/10/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	74,664.00	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)		21	7,686	74,664.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	11,496.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,150	86,160.00	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
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
	I/P Days / O/P Vi s i t s / Tri ps			Full Time Equivalents		
Component	Title VIII	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)	2,034	244	3,111			1.00
2.00 HMO	162	163				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,014	0	1,014			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	184			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,048	244	4,309			7.00
8.00 INTENSIVE CARE UNIT	310	0	479			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		0	141			13.00
14.00 Total (see instructions)	3,358	244	4,929	0.00	300.31	14.00
15.00 CAH visits	0	0	0			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	7,861	5,196	17,075	0.00	26.85	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	5,888	66	6,602	0.00	3.43	24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	130	706	3,177	0.00	3.36	26.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

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	
26.03	RURAL HEALTH CLINIC IV	771	447	5,058	0.00	4.21	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	338.16	27.00
28.00	Observation Bed Days		0	1,322			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
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	613	68	1,010	1.00
2.00	HMO			35			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	613	68	1,010	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
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-4
		Component CCN: 157149		Date/Time Prepared: 5/30/2013 1:34 pm
			Home Health Agency I	PPS

					1.00	
0.00	County					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	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	251.00	0.00	0.00	2.00

		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
Enter the number of hours in your normal work week					
		0	1.00	2.00	3.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	3.00
4.00	Director(s) and Assistant Director(s)	0.00			0.00	4.00
5.00	Other Administrative Personnel	0.00			0.00	5.00
6.00	Direct Nursing Service	0.00			0.00	6.00
7.00	Nursing Supervisor	0.00			0.00	7.00
8.00	Physical Therapy Service	0.00			0.00	8.00
9.00	Physical Therapy Supervisor	0.00			0.00	9.00
10.00	Occupational Therapy Service	0.00			0.00	10.00
11.00	Occupational Therapy Supervisor	0.00			0.00	11.00
12.00	Speech Pathology Service	0.00			0.00	12.00
13.00	Speech Pathology Supervisor	0.00			0.00	13.00
14.00	Medical Social Service	0.00			0.00	14.00
15.00	Medical Social Service Supervisor	0.00			0.00	15.00
16.00	Home Health Aide	0.00			0.00	16.00
17.00	Home Health Aide Supervisor	0.00			0.00	17.00
18.00	Other (specify)	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.				3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	23844				20.00
20.01		29140				20.01
20.02		99915				20.02

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00

PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,320	298	81	10	2,709
22.00	Skilled Nursing Visit Charges	308,560	39,634	10,773	1,330	360,297
23.00	Physical Therapy Visits	1,744	56	20	11	1,831
24.00	Physical Therapy Visit Charges	251,136	8,064	2,880	1,584	263,664
25.00	Occupational Therapy Visits	666	53	6	6	731
26.00	Occupational Therapy Visit Charges	95,904	7,632	864	864	105,264
27.00	Speech Pathology Visits	77	68	0	1	146
28.00	Speech Pathology Visit Charges	11,935	10,540	0	155	22,630
29.00	Medical Social Service Visits	21	0	0	0	21
30.00	Medical Social Service Visit Charges	4,347	0	0	0	4,347
31.00	Home Health Aide Visits	1,818	597	3	5	2,423
32.00	Home Health Aide Visit Charges	114,615	37,611	189	315	152,730
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,646	1,072	110	33	7,861
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	786,497	103,481	14,706	4,248	908,932
36.00	Total Number of Episodes (standard/non outlier)	313		42	5	360
37.00	Total Number of Outlier Episodes		13		0	13
38.00	Total Non-Routine Medical Supply Charges	22,012	2,089	200	41	24,342

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/30/2013 1:34 pm		
			Rural Health Clinic (RHC) I	Cost		
				1.00		
1.00	Clinic Address and Identification Street		492 S BIERMA ST	1.00		
		City	State	Zip Code		
		1.00	2.00	3.00		
2.00	City, State, Zip Code, County		WHEATFIELD IN 47978	2.00		
				1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00		
			Grant Award	Date		
			1.00	2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00		
7.00	Appalachian Regional Commission			0 7.00		
8.00	Look-Alikes			0 8.00		
9.00	OTHER (SPECIFY)			0 9.00		
9.01				0 9.01		
9.02				0 9.02		
9.03				0 9.03		
9.04				0 9.04		
9.05				0 9.05		
9.06				0 9.06		
9.07				0 9.07		
9.08				0 9.08		
9.09				0 9.09		
9.10				0 9.10		
				1.00 2.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0 10.00		
		Sunday	Monday	Tuesday		
		from to	from to	from		
		1.00 2.00	3.00 4.00	5.00		
11.00	Facility hours of operations (1) Clinic			08:00 17:00 08:00 11.00		
				1.00 2.00		
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 0 15.00		

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990		Period: From 01/01/2012 To 12/31/2012		Worksheet S-8 Date/Time Prepared: 5/30/2013 1:34 pm	
				Rural Health Clinic (RHC) I		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic	17:00		08:00		17:00	
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
11.00	Facility hours of operations (1) Clinic	08:00		17:00			

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/30/2013 1:34 pm	
			Rural Health Clinic (RHC) IV	Cost	
			1.00		
1.00	Clinic Address and Identification				
	Street	420 E MAIN ST		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		BROOK	IN	47922
			1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		0	4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00	
7.00	Appalachian Regional Commission		0	7.00	
8.00	Look-Alikes		0	8.00	
9.00	OTHER (SPECIFY)		0	9.00	
9.01			0	9.01	
9.02			0	9.02	
9.03			0	9.03	
9.04			0	9.04	
9.05			0	9.05	
9.06			0	9.06	
9.07			0	9.07	
9.08			0	9.08	
9.09			0	9.09	
9.10			0	9.10	
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	
		Sunday	Monday	Tuesday	
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)		08:00		17:00
	Clinic			08:00	
			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	
			Provider name		CCN number
			1.00		2.00
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0
			Total Visits		5.00
			0		15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502		Period: From 01/01/2012 To 12/31/2012		Worksheet S-8 Date/Time Prepared: 5/30/2013 1:34 pm	
				Rural Health Clinic (RHC) IV		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00	17:00				11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151324
Component CCN: 151519

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/30/2013 1:34 pm

		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	
2.00	Routine Home Care	5,927	60	1,474	1,228	518	6,505	
3.00	Inpatient Respite Care	47	0	0	0	5	52	
4.00	General Inpatient Care	35	6	0	0	6	47	
5.00	Total Hospice Days	6,009	66	1,474	1,228	529	6,604	
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	
9.00	Unduplicated Census Count	0	0	0	0	0	0	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/30/2013 1:34 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.619948	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,842,299	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		4,751,094	6.00
7.00	Medicaid cost (line 1 times line 6)		2,945,431	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,103,132	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,103,132	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	118,385	0	118,385
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	73,393	0	73,393
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	73,393	0	73,393
			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)		2,718,039	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		149,168	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,568,871	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,592,566	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,665,959	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,769,091	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151324		Period: From 01/01/2012 To 12/31/2012		Worksheet A	
Date/Time Prepared: 5/30/2013 1:34 pm								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,244,948	1,244,948	60,570	1,305,518	1.00
4.00	00400	EMPLOYEE BENEFITS	0	4,379,817	4,379,817	0	4,379,817	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,278,070	5,258,310	7,536,380	-64,670	7,471,710	5.00
7.00	00700	OPERATION OF PLANT	236,090	820,805	1,056,895	0	1,056,895	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,494	34,134	99,628	0	99,628	8.00
9.00	00900	HOUSEKEEPING	402,258	94,967	497,225	0	497,225	9.00
10.00	01000	DIETARY	338,628	206,719	545,347	-272,939	272,408	10.00
11.00	01100	CAFETERIA	0	0	0	272,939	272,939	11.00
13.00	01300	NURSING ADMINISTRATION	310,216	433	310,649	0	310,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,416	7,081	26,497	0	26,497	14.00
15.00	01500	PHARMACY	397,625	1,718,459	2,116,084	0	2,116,084	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	350,638	42,557	393,195	0	393,195	16.00
17.00	01700	SOCIAL SERVICE	0	131	131	48,925	49,056	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,940,394	139,928	2,080,322	-327,970	1,752,352	30.00
31.00	03100	INTENSIVE CARE UNIT	492,405	34,451	526,856	-8,864	517,992	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	280,035	280,035	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	535,330	1,867,130	2,402,460	-262	2,402,198	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	29,791	29,791	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,003,433	2,092,667	3,096,100	-53,948	3,042,152	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	784,265	694,412	1,478,677	0	1,478,677	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	88,769	88,769	0	88,769	63.00
65.00	06500	RESPIRATORY THERAPY	812,027	127,808	939,835	-2,065	937,770	65.00
66.00	06600	PHYSICAL THERAPY	1,250,210	162,004	1,412,214	-696,104	716,110	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	14,664	31,660	46,324	496,399	542,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	393,246	393,246	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	0	0	0	153,849	153,849	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	129,985	129,985	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	0	0	0	103,270	103,270	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	191,078	191,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	59,295	59,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	156,087	93,399	249,486	0	249,486	88.00
88.03	08801	RURAL HEALTH CLINIC IV	216,979	117,133	334,112	0	334,112	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	670,062	189,803	859,865	-124,672	735,193	90.00
91.00	09100	EMERGENCY	879,309	1,119,609	1,998,918	-42,418	1,956,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,378,321	192,125	1,570,446	-159,051	1,411,395	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	329,360	329,360	159,051	488,411	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,531,921	21,088,619	35,620,540	625,470	36,246,010	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ALTERNACARE	461,069	24,837	485,906	0	485,906	194.00
194.01	07951	DME EQUIPMENT	0	8,496	8,496	0	8,496	194.01
194.02	07952	KV HEALTH CENTER	812,764	128,025	940,789	-580,645	360,144	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	61,146	20,915	82,061	0	82,061	194.06
194.07	07956	ADVERTISING	65,119	76,956	142,075	-44,825	97,250	194.07
200.00		TOTAL (SUM OF LINES 118-199)	15,932,019	21,347,848	37,279,867	0	37,279,867	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-14,375	1,291,143	1.00
4.00	00400	EMPLOYEE BENEFITS	-48,252	4,331,565	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,499,349	4,972,361	5.00
7.00	00700	OPERATION OF PLANT	0	1,056,895	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,628	8.00
9.00	00900	HOUSEKEEPING	-81	497,144	9.00
10.00	01000	DIETARY	-11,829	260,579	10.00
11.00	01100	CAFETERIA	-58,118	214,821	11.00
13.00	01300	NURSING ADMINISTRATION	0	310,649	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,497	14.00
15.00	01500	PHARMACY	-77,424	2,038,660	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-15,184	378,011	16.00
17.00	01700	SOCIAL SERVICE	0	49,056	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-20,611	1,731,741	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,100	516,892	31.00
41.00	04100	SUBPROVIDER - IIRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	280,035	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-418,567	1,983,631	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,791	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,042,152	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-75	1,478,602	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	88,769	63.00
65.00	06500	RESPIRATORY THERAPY	0	937,770	65.00
66.00	06600	PHYSICAL THERAPY	-2,201	713,909	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0	542,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	393,246	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	0	153,849	67.01
68.00	06800	SPEECH PATHOLOGY	0	129,985	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	0	103,270	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-228	190,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	59,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-5,885	243,601	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	334,112	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-76,234	658,959	90.00
91.00	09100	EMERGENCY	-887,308	1,069,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,411,395	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	488,411	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,136,821	32,109,189	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	ALTERNACARE	0	485,906	194.00
194.01	07951	DME EQUIPMENT	0	8,496	194.01
194.02	07952	KV HEALTH CENTER	0	360,144	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	194.05
194.06	07955	WATER LAB	0	82,061	194.06
194.07	07956	ADVERTISING	0	97,250	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-4,136,821	33,143,046	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	169,479	103,460	1.00	
	TOTALS		169,479	103,460		
B - HOSPICE						
1.00	HOSPICE	116.00	159,051	0	1.00	
	TOTALS		159,051	0		
C - OB						
1.00	NURSERY	43.00	260,803	19,232	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	27,745	2,046	2.00	
	TOTALS		288,548	21,278		
D - CHARGEABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	250,373	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
	TOTALS		0	250,373		
E - KV CENTER RECLASS						
1.00	KV HEALTH & DEMOTTE PT	66.01	428,848	67,551	1.00	
2.00	KV HEALTH & DEMOTTE OT	67.01	132,913	20,936	2.00	
3.00	KV HEALTH & DEMOTTE ST	68.01	89,217	14,053	3.00	
	TOTALS		650,978	102,540		
F - ADVERTISING						
1.00	ADMINISTRATIVE & GENERAL	5.00	20,545	24,280	1.00	
	TOTALS		20,545	24,280		
G - PROPERTY INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	60,570	1.00	
	TOTALS		0	60,570		
H - REHAB RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	374,480	18,766	1.00	
2.00	SPEECH PATHOLOGY	68.00	123,782	6,203	2.00	
3.00	KV HEALTH CENTER	194.02	164,623	8,250	3.00	
	TOTALS		662,885	33,219		
I - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	59,295	1.00	
	TOTALS		0	59,295		
J - SOCIAL SERVICE RECLASS						
1.00	SOCIAL SERVICE	17.00	48,925	0	1.00	
	TOTALS		48,925	0		
500.00	Grand Total: Increases		2,000,411	655,015	500.00	

RECLASSIFICATIONS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/30/2013 1:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	169,479	103,460	0		1.00
	TOTALS		169,479	103,460			
B - HOSPICE							
1.00	HOME HEALTH AGENCY	101.00	159,051	0	0		1.00
	TOTALS		159,051	0			
C - OB							
1.00	ADULTS & PEDIATRICS	30.00	288,548	21,278	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		288,548	21,278			
D - CHARGEABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	18,144	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	8,864	0		2.00
3.00	OPERATING ROOM	50.00	0	262	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,948	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	2,065	0		5.00
6.00	CLINIC	90.00	0	124,672	0		6.00
7.00	EMERGENCY	91.00	0	42,418	0		7.00
	TOTALS		0	250,373			
E - KV CENTER RECLASS							
1.00	KV HEALTH CENTER	194.02	650,978	102,540	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		650,978	102,540			
F - ADVERTISING							
1.00	ADVERTISING	194.07	20,545	24,280	0		1.00
	TOTALS		20,545	24,280			
G - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,570	12		1.00
	TOTALS		0	60,570			
H - REHAB RECLASS							
1.00	PHYSICAL THERAPY	66.00	662,885	33,219	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		662,885	33,219			
I - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	59,295	0		1.00
	TOTALS		0	59,295			
J - SOCIAL SERVICE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	48,925	0	0		1.00
	TOTALS		48,925	0			
500.00	Grand Total: Decreases		2,000,411	655,015			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	53,965	0	0	0	1.00
2.00	Land Improvements	1,859,740	0	0	0	2.00
3.00	Buildings and Fixtures	20,985,577	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	918,461	0	0	0	5.00
6.00	Movable Equipment	5,034,119	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,851,862	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,851,862	0	0	0	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	53,965	0			1.00
2.00	Land Improvements	1,859,740	0			2.00
3.00	Buildings and Fixtures	20,985,577	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	918,461	0			5.00
6.00	Movable Equipment	5,034,119	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	28,851,862	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	28,851,862	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	586,438	9,497	649,013	0	0	1.00
3.00	Total (sum of lines 1-2)	586,438	9,497	649,013	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,244,948				1.00
3.00	Total (sum of lines 1-2)	0	1,244,948				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part III
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,851,862	0	28,851,862	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	28,851,862	0	28,851,862	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	572,063	9,497	1.00
3.00	Total (sum of lines 1-2)	0	0	0	572,063	9,497	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	649,013	60,570	0	0	1,291,143	1.00
3.00	Total (sum of lines 1-2)	649,013	60,570	0	0	1,291,143	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			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
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	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	-876,883	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-15,144	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	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
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 WELLNESS PROGRAM FEE	B	-2,201	0	PHYSICAL THERAPY	66.00	0	33.00
34.00 MEALS ON WHEELS	B	-11,829	0	DIETARY	10.00	0	34.00
35.00 MISCELLANEOUS INCOME BENEFITS	B	-48,252	0	EMPLOYEE BENEFITS	4.00	0	35.00

Provider CCN: 151324

Period:
 From 01/01/2012
 To 12/31/2012

Worksheet A-8

Date/Time Prepared:
 5/30/2013 1:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
36.00 MI SCCELLANEOUS INCOME ADMIN	B	-407,095	ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 MI SCCELLANEOUS INCOME HOUSEKEEPING	B	-81	HOUSEKEEPING	9.00	0 37.00
38.00 MI SCCELLANEOUS INCOME PHARMACY	B	-77,424	PHARMACY	15.00	0 38.00
39.00 MI SCCELLANEOUS INCOME MEDICAL RECORDS	B	-40	MEDICAL RECORDS & LIBRARY	16.00	0 39.00
40.00 MI SCCELLANEOUS INCOME A&P	B	-486	ADULTS & PEDIATRICS	30.00	0 40.00
41.00 MI SCCELLANEOUS SUPPLIES	B	-228	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 41.00
42.00 MI SCCELLANEOUS INCOME CLINIC	B	-5,885	RURAL HEALTH CLINIC	88.00	0 42.00
43.00 MI SCCELLANEOUS INCOME CARE	B	-70,559	CLINIC	90.00	0 43.00
44.00 LI FELINE	B	-7,500	EMERGENCY	91.00	0 44.00
45.00 MI SCCELLANEOUS INCOME ADMIN	B	-407	ADMINISTRATIVE & GENERAL	5.00	0 45.00
45.01 CAFETERIA	A	-58,118	CAFETERIA	11.00	0 45.01
45.02 INTEREST INCOME	A	-4,504	ADMINISTRATIVE & GENERAL	5.00	0 45.02
45.03 LOBBYING EXPENSE	A	-962	ADMINISTRATIVE & GENERAL	5.00	0 45.03
45.04 GOODWILL AMORTIZATION	A	-14,375	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 45.04
45.05 ANESTHESIA OFFSET	A	-20,125	ADULTS & PEDIATRICS	30.00	0 45.05
45.06 ANESTHESIA OFFSET	A	-1,100	INTENSIVE CARE UNIT	31.00	0 45.06
45.07 ANESTHESIA OFFSET	A	-418,567	OPERATING ROOM	50.00	0 45.07
45.08 ANESTHESIA OFFSET	A	-75	LABORATORY	60.00	0 45.08
45.09 ANESTHESIA OFFSET	A	-5,675	CLINIC	90.00	0 45.09
45.10 ANESTHESIA OFFSET	A	-2,925	EMERGENCY	91.00	0 45.10
45.11 HAF OFFSET	A	-2,086,381	ADMINISTRATIVE & GENERAL	5.00	0 45.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,136,821			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/30/2013 1:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	91.00	EMERGENCY	1,037,657	876,883	160,774	0	0	2.00
3.00	0.00		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			1,061,657	876,883	184,774	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		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	60.00	LABORATORY	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	876,883	2.00
3.00	0.00		0	0	0	0	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	876,883	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324		Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 1:34 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					5.51	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,622.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.72	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.86	37.86	0.00			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)					122,818	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					122,818	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)					122,818	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)					122,818	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324				Period: From 01/01/2012 To 12/31/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2013 1:34 pm		
						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	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	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)	75.72	0.00	0.00	0.00			52.00		
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00		
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00		
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00		
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00		
								1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT										
57.00	Salary equivalency amount (from line 23)							122,818		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0		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)							122,818		63.00
64.00	Total cost of outside supplier services (from your records)							99,354		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							0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0		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							0		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							0		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: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,291,143	1,291,143				1.00
4.00 00400	EMPLOYEE BENEFITS	4,331,565	0	4,331,565			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,972,361	83,772	611,640	5,667,773	5,667,773	5.00
7.00 00700	OPERATION OF PLANT	1,056,895	22,727	64,188	1,143,810	235,952	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	99,628	19,695	17,806	137,129	28,288	8.00
9.00 00900	HOUSEKEEPING	497,144	23,312	109,365	629,821	129,923	9.00
10.00 01000	DIETARY	260,579	23,129	45,988	329,696	68,012	10.00
11.00 01100	CAFETERIA	214,821	23,178	46,078	284,077	58,601	11.00
13.00 01300	NURSING ADMINISTRATION	310,649	4,908	84,341	399,898	82,493	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	26,497	0	5,279	31,776	6,555	14.00
15.00 01500	PHARMACY	2,038,660	12,277	108,105	2,159,042	445,380	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	378,011	16,625	95,331	489,967	101,073	16.00
17.00 01700	SOCIAL SERVICE	49,056	1,133	13,302	63,491	13,097	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,731,741	169,163	449,101	2,350,005	484,773	30.00
31.00 03100	INTENSIVE CARE UNIT	516,892	9,208	133,874	659,974	136,143	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	280,035	3,069	70,907	354,011	73,028	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,983,631	139,701	145,544	2,268,876	468,037	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	29,791	6,212	7,543	43,546	8,983	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,042,152	117,217	272,811	3,432,180	708,018	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,478,602	30,011	213,224	1,721,837	355,191	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	88,769	2,436	0	91,205	18,814	63.00
65.00 06500	RESPIRATORY THERAPY	937,770	39,438	220,772	1,197,980	247,127	65.00
66.00 06600	PHYSICAL THERAPY	713,909	31,521	159,681	905,111	186,712	66.00
66.01 06601	KV HEALTH & DEMOTTE PT	542,723	97,584	120,581	760,888	156,961	66.01
67.00 06700	OCCUPATIONAL THERAPY	393,246	17,904	101,813	512,963	105,817	67.00
67.01 06701	KV HEALTH & DEMOTTE OT	153,849	30,242	36,136	220,227	45,430	67.01
68.00 06800	SPEECH PATHOLOGY	129,985	5,919	33,654	169,558	34,977	68.00
68.01 06801	KV HEALTH & DEMOTTE ST	103,270	20,304	24,256	147,830	30,495	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	190,850	13,069	0	203,919	42,066	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	59,295	2,594	0	61,889	12,767	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	243,601	0	42,437	286,038	59,066	88.00
88.03 08801	RURAL HEALTH CLINIC IV	334,112	32,276	58,992	425,380	87,750	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	658,959	53,384	182,175	894,518	184,527	90.00
91.00 09100	EMERGENCY	1,069,192	54,370	239,065	1,362,627	281,091	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	1,411,395	37,586	331,493	1,780,474	367,287	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	488,411	3,033	43,242	534,686	110,298	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	32,109,189	1,146,997	4,088,724	31,722,202	5,374,672	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,801	0	2,801	578	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	485,906	101,846	125,355	713,107	147,104	194.00
194.01 07951	DME EQUIPMENT	8,496	0	0	8,496	1,753	194.01
194.02 07952	KV HEALTH CENTER	360,144	30,011	88,743	478,898	98,790	194.02
194.04 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	82,061	6,748	16,624	105,433	21,749	194.06
194.07 07956	ADVERTISING	97,250	2,740	12,119	112,109	23,127	194.07
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	33,143,046	1,291,143	4,331,565	33,143,046	5,667,773	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

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
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,379,762				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,938	188,355			8.00
9.00	00900	HOUSEKEEPING	27,152	0	786,896		9.00
10.00	01000	DIETARY	26,939	0	1,490	426,137	10.00
11.00	01100	CAFETERIA	26,995	0	1,655	0	371,328
13.00	01300	NURSING ADMINISTRATION	5,717	0	0	0	8,469
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	14,299	0	6,014	0	11,266
16.00	01600	MEDICAL RECORDS & LIBRARY	19,364	0	0	0	19,818
17.00	01700	SOCIAL SERVICE	1,319	0	0	0	2,047
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	197,026	67,440	325,927	251,865	70,691
31.00	03100	INTENSIVE CARE UNIT	10,724	9,037	33,217	22,474	16,508
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,575	2,561	6,621	0	8,145
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	162,710	12,047	0	0	17,866
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,235	272	4,856	0	866
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,524	12,412	100,314	0	33,695
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	34,954	0	24,499	0	31,594
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,837	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	45,933	1,568	28,858	0	29,577
66.00	06600	PHYSICAL THERAPY	36,713	20,772	16,940	0	17,836
66.01	06601	KV HEALTH & DEMOTTE PT	113,656	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	20,853	0	9,623	0	11,372
67.01	06701	KV HEALTH & DEMOTTE OT	35,223	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	6,894	0	3,178	0	3,759
68.01	06801	KV HEALTH & DEMOTTE ST	23,648	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,221	0	0	0	1,878
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,022	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.03	08801	RURAL HEALTH CLINIC IV	37,592	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	62,176	13,466	0	4,453	21,027
91.00	09100	EMERGENCY	63,325	17,570	70,242	0	32,549
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	43,777	0	18,761	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	3,532	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,211,873	157,145	652,195	278,792	338,963
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,263	0	1,766	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ALTERNACARE	118,621	31,210	129,735	147,345	27,026
194.01	07951	DME EQUIPMENT	0	0	0	0	0
194.02	07952	KV HEALTH CENTER	34,954	0	0	0	0
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.05	07954	MEALS ON WHEELS	0	0	0	0	0
194.06	07955	WATER LAB	7,859	0	3,200	0	2,785
194.07	07956	ADVERTISING	3,192	0	0	0	2,554
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,379,762	188,355	786,896	426,137	371,328

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	496,577					13.00
14.00	01400	0	38,331				14.00
15.00	01500	0	0	2,636,001			15.00
16.00	01600	0	0	0	630,222		16.00
17.00	01700	0	0	0	0	79,954	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	172,732	0	0	259,202	72,899	30.00
31.00	03100	40,338	0	0	0	7,055	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	19,903	0	0	3,352	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	43,655	0	0	62,314	0	50.00
52.00	05200	2,117	0	0	357	0	52.00
54.00	05400	82,332	0	0	77,536	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	13,399	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
67.01	06701	0	0	0	0	0	67.01
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	0	0	68.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	4,588	38,331	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	2,636,001	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.03	08801	0	0	0	0	0	88.03
89.00	08900	0	0	0	0	0	89.00
90.00	09000	51,378	0	0	159,661	0	90.00
91.00	09100	79,534	0	0	54,401	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		496,577	38,331	2,636,001	630,222	79,954	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		496,577	38,331	2,636,001	630,222	79,954	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,252,560	0	4,252,560	30.00
31.00	03100	935,470	0	935,470	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	471,196	0	471,196	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	3,035,505	0	3,035,505	50.00
52.00	05200	68,232	0	68,232	52.00
54.00	05400	4,583,011	0	4,583,011	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	2,181,474	0	2,181,474	60.00
60.01	06001	0	0	0	60.01
63.00	06300	112,856	0	112,856	63.00
65.00	06500	1,551,043	0	1,551,043	65.00
66.00	06600	1,184,084	0	1,184,084	66.00
66.01	06601	1,031,505	0	1,031,505	66.01
67.00	06700	660,628	0	660,628	67.00
67.01	06701	300,880	0	300,880	67.01
68.00	06800	218,366	0	218,366	68.00
68.01	06801	201,973	0	201,973	68.01
70.00	07000	0	0	0	70.00
71.00	07100	306,003	0	306,003	71.00
72.00	07200	77,678	0	77,678	72.00
73.00	07300	2,636,001	0	2,636,001	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	345,044	0	345,044	88.00
88.03	08801	550,722	0	550,722	88.03
89.00	08900	0	0	0	89.00
90.00	09000	1,391,206	0	1,391,206	90.00
91.00	09100	1,961,339	0	1,961,339	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	2,210,299	0	2,210,299	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	648,516	0	648,516	116.00
118.00		30,915,591	0	30,915,591	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	8,408	0	8,408	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
193.00	19300	0	0	0	193.00
194.00	07950	1,314,148	0	1,314,148	194.00
194.01	07951	10,249	0	10,249	194.01
194.02	07952	612,642	0	612,642	194.02
194.04	07953	0	0	0	194.04
194.05	07954	0	0	0	194.05
194.06	07955	141,026	0	141,026	194.06
194.07	07956	140,982	0	140,982	194.07
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		33,143,046	0	33,143,046	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	83,772	83,772	0	83,772	5.00
7.00 00700	OPERATION OF PLANT	0	22,727	22,727	0	3,487	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	19,695	19,695	0	418	8.00
9.00 00900	HOUSEKEEPING	0	23,312	23,312	0	1,920	9.00
10.00 01000	DIETARY	0	23,129	23,129	0	1,005	10.00
11.00 01100	CAFETERIA	0	23,178	23,178	0	866	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,908	4,908	0	1,219	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	97	14.00
15.00 01500	PHARMACY	0	12,277	12,277	0	6,583	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,625	16,625	0	1,494	16.00
17.00 01700	SOCIAL SERVICE	0	1,133	1,133	0	194	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	169,163	169,163	0	7,165	30.00
31.00 03100	INTENSIVE CARE UNIT	0	9,208	9,208	0	2,012	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	3,069	3,069	0	1,079	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	139,701	139,701	0	6,918	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	6,212	6,212	0	133	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	117,217	117,217	0	10,465	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	30,011	30,011	0	5,250	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	2,436	2,436	0	278	63.00
65.00 06500	RESPIRATORY THERAPY	0	39,438	39,438	0	3,653	65.00
66.00 06600	PHYSICAL THERAPY	0	31,521	31,521	0	2,760	66.00
66.01 06601	KV HEALTH & DEMOTTE PT	0	97,584	97,584	0	2,320	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	17,904	17,904	0	1,564	67.00
67.01 06701	KV HEALTH & DEMOTTE OT	0	30,242	30,242	0	671	67.01
68.00 06800	SPEECH PATHOLOGY	0	5,919	5,919	0	517	68.00
68.01 06801	KV HEALTH & DEMOTTE ST	0	20,304	20,304	0	451	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,069	13,069	0	622	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	2,594	2,594	0	189	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	872	88.00
88.03 08801	RURAL HEALTH CLINIC IV	0	32,276	32,276	0	1,297	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	53,384	53,384	0	2,727	90.00
91.00 09100	EMERGENCY	0	54,370	54,370	0	4,155	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	37,586	37,586	0	5,429	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	0	3,033	3,033	0	1,630	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,146,997	1,146,997	0	79,440	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,801	2,801	0	9	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	0	101,846	101,846	0	2,174	194.00
194.01 07951	DME EQUIPMENT	0	0	0	0	26	194.01
194.02 07952	KV HEALTH CENTER	0	30,011	30,011	0	1,460	194.02
194.04 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	0	6,748	6,748	0	321	194.06
194.07 07956	ADVERTISING	0	2,740	2,740	0	342	194.07
200.00	Cross Foot Adjustments		0	0			200.00
201.00	Negative Cost Centers		0	0		0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,291,143	1,291,143	0	83,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/30/2013 1:34 pm
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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	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	26,214				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	436	20,549			8.00	
9.00	00900	HOUSEKEEPING	516	0	25,748		9.00	
10.00	01000	DIETARY	512	0	49	24,695	10.00	
11.00	01100	CAFETERIA	513	0	54	0	11.00	
13.00	01300	NURSING ADMINISTRATION	109	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	272	0	197	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	368	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	25	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,743	7,358	10,664	14,596	4,686	30.00
31.00	03100	INTENSIVE CARE UNIT	204	986	1,087	1,302	1,094	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	68	279	217	0	540	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,091	1,314	0	0	1,184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	137	30	159	0	57	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,594	1,354	3,282	0	2,233	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	664	0	802	0	2,094	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	54	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	873	171	944	0	1,960	65.00
66.00	06600	PHYSICAL THERAPY	698	2,266	554	0	1,182	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	2,159	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	396	0	315	0	754	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	669	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	131	0	104	131	249	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	449	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	289	0	0	0	124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	57	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	714	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,181	1,469	0	258	1,394	90.00
91.00	09100	EMERGENCY	1,203	1,917	2,298	0	2,157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	832	0	614	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	67	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,024	17,144	21,340	16,156	22,466	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	62	0	58	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ALTERNACARE	2,254	3,405	4,245	8,539	1,791	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02	07952	KV HEALTH CENTER	664	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	07955	WATER LAB	149	0	105	0	185	194.06
194.07	07956	ADVERTISING	61	0	0	0	169	194.07
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)	26,214	20,549	25,748	24,695	24,611	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	6,797					13.00
14.00	01400	0	97				14.00
15.00	01500	0	0	20,076			15.00
16.00	01600	0	0	0	19,801		16.00
17.00	01700	0	0	0	0	1,488	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,364	0	0	8,145	1,357	30.00
31.00	03100	552	0	0	0	131	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	272	0	0	105	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	598	0	0	1,958	0	50.00
52.00	05200	29	0	0	11	0	52.00
54.00	05400	1,127	0	0	2,436	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	421	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
67.01	06701	0	0	0	0	0	67.01
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	0	0	68.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	63	97	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	20,076	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
88.03	08801	0	0	0	0	0	88.03
89.00	08900	0	0	0	0	0	89.00
90.00	09000	703	0	0	5,016	0	90.00
91.00	09100	1,089	0	0	1,709	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		6,797	97	20,076	19,801	1,488	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.04	07953	0	0	0	0	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		6,797	97	20,076	19,801	1,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	229,241	0	229,241	30.00
31.00	03100	16,576	0	16,576	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	5,629	0	5,629	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	154,764	0	154,764	50.00
52.00	05200	6,768	0	6,768	52.00
54.00	05400	140,708	0	140,708	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	39,242	0	39,242	60.00
60.01	06001	0	0	0	60.01
63.00	06300	2,768	0	2,768	63.00
65.00	06500	47,039	0	47,039	65.00
66.00	06600	38,981	0	38,981	66.00
66.01	06601	102,063	0	102,063	66.01
67.00	06700	20,933	0	20,933	67.00
67.01	06701	31,582	0	31,582	67.01
68.00	06800	6,920	0	6,920	68.00
68.01	06801	21,204	0	21,204	68.01
70.00	07000	0	0	0	70.00
71.00	07100	14,264	0	14,264	71.00
72.00	07200	2,840	0	2,840	72.00
73.00	07300	20,076	0	20,076	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	872	0	872	88.00
88.03	08801	34,287	0	34,287	88.03
89.00	08900	0	0	0	89.00
90.00	09000	66,132	0	66,132	90.00
91.00	09100	68,898	0	68,898	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	44,461	0	44,461	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	4,730	0	4,730	116.00
118.00		1,120,978	0	1,120,978	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	2,930	0	2,930	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
193.00	19300	0	0	0	193.00
194.00	07950	124,254	0	124,254	194.00
194.01	07951	26	0	26	194.01
194.02	07952	32,135	0	32,135	194.02
194.04	07953	0	0	0	194.04
194.05	07954	0	0	0	194.05
194.06	07955	7,508	0	7,508	194.06
194.07	07956	3,312	0	3,312	194.07
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,291,143	0	1,291,143	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	106,008					1.00
4.00 00400	EMPLOYEE BENEFITS	0	15,932,019				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,878	2,249,690	-5,667,773	27,475,273		5.00
7.00 00700	OPERATION OF PLANT	1,866	236,090	0	1,143,810	97,264	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,617	65,494	0	137,129	1,617	8.00
9.00 00900	HOUSEKEEPING	1,914	402,258	0	629,821	1,914	9.00
10.00 01000	DIETARY	1,899	169,149	0	329,696	1,899	10.00
11.00 01100	CAFETERIA	1,903	169,479	0	284,077	1,903	11.00
13.00 01300	NURSING ADMINISTRATION	403	310,216	0	399,898	403	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	19,416	0	31,776	0	14.00
15.00 01500	PHARMACY	1,008	397,625	0	2,159,042	1,008	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,365	350,638	0	489,967	1,365	16.00
17.00 01700	SOCIAL SERVICE	93	48,925	0	63,491	93	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	13,889	1,651,846	0	2,350,005	13,889	30.00
31.00 03100	INTENSIVE CARE UNIT	756	492,405	0	659,974	756	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	252	260,803	0	354,011	252	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	11,470	535,330	0	2,268,876	11,470	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	510	27,745	0	43,546	510	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,624	1,003,433	0	3,432,180	9,624	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,464	784,265	0	1,721,837	2,464	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	200	0	0	91,205	200	63.00
65.00 06500	RESPIRATORY THERAPY	3,238	812,027	0	1,197,980	3,238	65.00
66.00 06600	PHYSICAL THERAPY	2,588	587,325	0	905,111	2,588	66.00
66.01 06601	KV HEALTH & DEMOTTE PT	8,012	443,512	0	760,888	8,012	66.01
67.00 06700	OCCUPATIONAL THERAPY	1,470	374,480	0	512,963	1,470	67.00
67.01 06701	KV HEALTH & DEMOTTE OT	2,483	132,913	0	220,227	2,483	67.01
68.00 06800	SPEECH PATHOLOGY	486	123,782	0	169,558	486	68.00
68.01 06801	KV HEALTH & DEMOTTE ST	1,667	89,217	0	147,830	1,667	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,073	0	0	203,919	1,073	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	213	0	0	61,889	213	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	156,087	0	286,038	0	88.00
88.03 08801	RURAL HEALTH CLINIC IV	2,650	216,979	0	425,380	2,650	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	4,383	670,062	0	894,518	4,383	90.00
91.00 09100	EMERGENCY	4,464	879,309	0	1,362,627	4,464	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	3,086	1,219,270	0	1,780,474	3,086	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	249	159,051	0	534,686	249	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,173	15,038,821	-5,667,773	26,054,429	85,429	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	2,801	230	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	8,362	461,069	0	713,107	8,362	194.00
194.01 07951	DME EQUIPMENT	0	0	0	8,496	0	194.01
194.02 07952	KV HEALTH CENTER	2,464	326,409	0	478,898	2,464	194.02
194.04 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	554	61,146	0	105,433	554	194.06
194.07 07956	ADVERTISING	225	44,574	0	112,109	225	194.07
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)	1,291,143	4,331,565		5,667,773	1,379,762	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					
	1.00	4.00					
203.00	Unit cost multiplier (Wkst. B, Part I)	12.179675	0.271878	5A	0.206286	14.185742	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		83,772	26,214	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.003049	0.269514	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800	52,004					8.00	
9.00	00900	0	142,610				9.00	
10.00	01000	0	270	43,156			10.00	
11.00	01100	0	300	0	393,923		11.00	
13.00	01300	0	0	0	8,984	215,591	13.00	
14.00	01400	0	0	0	0	0	14.00	
15.00	01500	0	1,090	0	11,952	0	15.00	
16.00	01600	0	0	0	21,024	0	16.00	
17.00	01700	0	0	0	2,172	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	18,620	59,068	25,507	74,992	74,992	30.00	
31.00	03100	2,495	6,020	2,276	17,513	17,513	31.00	
41.00	04100	0	0	0	0	0	41.00	
42.00	04200	0	0	0	0	0	42.00	
43.00	04300	707	1,200	0	8,641	8,641	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	3,326	0	0	18,953	18,953	50.00	
52.00	05200	75	880	0	919	919	52.00	
54.00	05400	3,427	18,180	0	35,745	35,745	54.00	
57.00	05700	0	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	4,440	0	33,516	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
63.00	06300	0	0	0	0	0	63.00	
65.00	06500	433	5,230	0	31,377	0	65.00	
66.00	06600	5,735	3,070	0	18,921	0	66.00	
66.01	06601	0	0	0	0	0	66.01	
67.00	06700	0	1,744	0	12,064	0	67.00	
67.01	06701	0	0	0	0	0	67.01	
68.00	06800	0	576	0	3,988	0	68.00	
68.01	06801	0	0	0	0	0	68.01	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	1,992	1,992	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
88.03	08801	0	0	0	0	0	88.03	
89.00	08900	0	0	0	0	0	89.00	
90.00	09000	3,718	0	451	22,306	22,306	90.00	
91.00	09100	4,851	12,730	0	34,530	34,530	91.00	
92.00	09200	0	0	0	0	0	92.00	
93.00	04040	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	3,400	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
116.00	11600	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		43,387	118,198	28,234	359,589	215,591	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	320	0	0	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	8,617	23,512	14,922	28,671	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
194.04	07953	0	0	0	0	0	194.04	
194.05	07954	0	0	0	0	0	194.05	
194.06	07955	0	580	0	2,954	0	194.06	
194.07	07956	0	0	0	2,709	0	194.07	
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)		188,355	786,896	426,137	371,328	496,577	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		3.621933	5.517818	9.874340	0.942641	2.303329	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	20,549	25,748	24,695	24,611	6,797	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.395143	0.180548	0.572226	0.062477	0.031527	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	178,404		16.00
17.00	01700	0	0	0	510	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	0	73,375	465	30.00
31.00	03100	0	0	0	45	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	0	949	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	17,640	0	50.00
52.00	05200	0	0	101	0	52.00
54.00	05400	0	0	21,949	0	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	3,793	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	0	0	66.00
66.01	06601	0	0	0	0	66.01
67.00	06700	0	0	0	0	67.00
67.01	06701	0	0	0	0	67.01
68.00	06800	0	0	0	0	68.00
68.01	06801	0	0	0	0	68.01
70.00	07000	0	0	0	0	70.00
71.00	07100	100	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
88.03	08801	0	0	0	0	88.03
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	45,197	0	90.00
91.00	09100	0	0	15,400	0	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	0	116.00
118.00		100	100	178,404	510	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.04	07953	0	0	0	0	194.04
194.05	07954	0	0	0	0	194.05
194.06	07955	0	0	0	0	194.06
194.07	07956	0	0	0	0	194.07
200.00						200.00
201.00						201.00
202.00		38,331	2,636,001	630,222	79,954	202.00
203.00		383.310000	26,360.010000	3.532555	156.772549	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	97	20,076	19,801	1,488		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.970000	200.760000	0.110990	2.917647		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

			Title XVIII		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,252,560		4,252,560	0	0	2,966,897	30.00
31.00	03100	INTENSIVE CARE UNIT	935,470		935,470	0	0	624,560	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	471,196		471,196	0	0	81,585	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,035,505		3,035,505	0	0	904,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,232		68,232	0	0	81,088	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,583,011		4,583,011	0	0	732,896	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	2,181,474		2,181,474	0	0	1,412,550	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	112,856		112,856	0	0	143,057	63.00
65.00	06500	RESPIRATORY THERAPY	1,551,043	0	1,551,043	0	0	1,321,617	65.00
66.00	06600	PHYSICAL THERAPY	1,184,084	0	1,184,084	0	0	237,520	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	1,031,505	0	1,031,505	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	660,628	0	660,628	0	0	165,206	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	300,880	0	300,880	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	218,366	0	218,366	0	0	42,005	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	201,973	0	201,973	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,003		306,003	0	0	188,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	77,678		77,678	0	0	39,900	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,636,001		2,636,001	0	0	1,932,825	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	345,044		345,044	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	550,722		550,722	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	1,391,206		1,391,206	0	0	185,911	90.00
91.00	09100	EMERGENCY	1,961,339		1,961,339	0	0	31,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,024,008		1,024,008	0	0	364,364	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	2,210,299		2,210,299		0	0	101.00
SPECIAL PURPOSE COST CENTERS									
116.00	11600	HOSPICE	648,516		648,516	0	0	0	116.00
200.00		Subtotal (see instructions)	31,939,599	0	31,939,599	0	0	11,456,281	200.00
201.00		Less Observation Beds	1,024,008		1,024,008		0	0	201.00
202.00		Total (see instructions)	30,915,591	0	30,915,591	0	0	11,456,281	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital Cost
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00	9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		2,966,897				30.00
31.00	03100	INTENSIVE CARE UNIT		624,560				31.00
41.00	04100	SUBPROVIDER - IRF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		81,585				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,517,431	4,422,130	0.686435	0.000000	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,203	118,291	0.576815	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,989,607	7,722,503	0.593462	0.000000	0.000000	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	6,538,258	7,950,808	0.274371	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	143,058	286,115	0.394443	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,303,591	2,625,208	0.590827	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,450,646	1,688,166	0.701403	0.000000	0.000000	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	1,277,570	1,277,570	0.807396	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	342,416	507,622	1.301417	0.000000	0.000000	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	222,218	222,218	1.353986	0.000000	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	129,649	171,654	1.272129	0.000000	0.000000	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	125,242	125,242	1.612662	0.000000	0.000000	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	705,362	893,869	0.342335	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	137,984	177,884	0.436678	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,326,178	7,259,003	0.363135	0.000000	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	209,290	209,290				88.00
88.03	08801	RURAL HEALTH CLINIC IV	356,037	356,037				88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000	CLINIC	2,581,357	2,767,268	0.502736	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,735,076	1,766,170	1.110504	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,548,670	2,913,034	0.351526	0.000000	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,497,919	1,497,919				101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,237,019	1,237,019				116.00
200.00		Subtotal (see instructions)	38,411,781	49,868,062				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	38,411,781	49,868,062				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,252,560		4,252,560	0	0	2,966,897	30.00
31.00	03100	INTENSIVE CARE UNIT	935,470		935,470	0	0	624,560	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	0	42.00
43.00	04300	NURSERY	471,196		471,196	0	0	81,585	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,035,505		3,035,505	0	0	904,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,232		68,232	0	0	81,088	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,583,011		4,583,011	0	0	732,896	54.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00	06000	LABORATORY	2,181,474		2,181,474	0	0	1,412,550	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	112,856		112,856	0	0	143,057	63.00
65.00	06500	RESPIRATORY THERAPY	1,551,043	0	1,551,043	0	0	1,321,617	65.00
66.00	06600	PHYSICAL THERAPY	1,184,084	0	1,184,084	0	0	237,520	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	1,031,505	0	1,031,505	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	660,628	0	660,628	0	0	165,206	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	300,880	0	300,880	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	218,366	0	218,366	0	0	42,005	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	201,973	0	201,973	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	306,003		306,003	0	0	188,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	77,678		77,678	0	0	39,900	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,636,001		2,636,001	0	0	1,932,825	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	345,044		345,044	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	550,722		550,722	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00	09000	CLINIC	1,391,206		1,391,206	0	0	185,911	90.00
91.00	09100	EMERGENCY	1,961,339		1,961,339	0	0	31,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,024,008		1,024,008	0	0	364,364	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	2,210,299		2,210,299		0	0	101.00
SPECIAL PURPOSE COST CENTERS									
116.00	11600	HOSPICE	648,516		648,516	0	0	0	116.00
200.00		Subtotal (see instructions)	31,939,599	0	31,939,599	0	0	11,456,281	200.00
201.00		Less Observation Beds	1,024,008		1,024,008		0		201.00
202.00		Total (see instructions)	30,915,591	0	30,915,591	0	0	11,456,281	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

			Title XIX		Hospital		Cost	
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	Outpatient	Total (col. 6 + col. 7)						
	7.00	8.00				9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		2,966,897				30.00
31.00	03100	INTENSIVE CARE UNIT		624,560				31.00
41.00	04100	SUBPROVIDER - IRF		0				41.00
42.00	04200	SUBPROVIDER		0				42.00
43.00	04300	NURSERY		81,585				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,517,431	4,422,130	0.686435	0.000000	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,203	118,291	0.576815	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,989,607	7,722,503	0.593462	0.000000	0.000000	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0.000000	59.00
60.00	06000	LABORATORY	6,538,258	7,950,808	0.274371	0.000000	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	143,058	286,115	0.394443	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,303,591	2,625,208	0.590827	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,450,646	1,688,166	0.701403	0.000000	0.000000	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	1,277,570	1,277,570	0.807396	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	342,416	507,622	1.301417	0.000000	0.000000	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	222,218	222,218	1.353986	0.000000	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	129,649	171,654	1.272129	0.000000	0.000000	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	125,242	125,242	1.612662	0.000000	0.000000	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	705,362	893,869	0.342335	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	137,984	177,884	0.436678	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,326,178	7,259,003	0.363135	0.000000	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	209,290	209,290	1.648641	0.000000	0.000000	88.00
88.03	08801	RURAL HEALTH CLINIC IV	356,037	356,037	1.546811	0.000000	0.000000	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0.000000	89.00
90.00	09000	CLINIC	2,581,357	2,767,268	0.502736	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	1,735,076	1,766,170	1.110504	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,548,670	2,913,034	0.351526	0.000000	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,497,919	1,497,919				101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,237,019	1,237,019				116.00
200.00		Subtotal (see instructions)	38,411,781	49,868,062				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	38,411,781	49,868,062				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 1:34 pm
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Cost Center Description		Title XVIII			Hospital		Capital Costs (column 3 x column 4)	
		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	154,764	4,422,130	0.034998	231,950	8,118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,768	118,291	0.057215	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,708	7,722,503	0.018221	519,345	9,463	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	39,242	7,950,808	0.004936	851,145	4,201	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,768	286,115	0.009674	66,137	640	63.00
65.00	06500	RESPIRATORY THERAPY	47,039	2,625,208	0.017918	1,009,760	18,093	65.00
66.00	06600	PHYSICAL THERAPY	38,981	1,688,166	0.023091	94,111	2,173	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	102,063	1,277,570	0.079888	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	20,933	507,622	0.041237	59,319	2,446	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	31,582	222,218	0.142122	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	6,920	171,654	0.040314	22,560	909	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	21,204	125,242	0.169304	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,264	893,869	0.015958	52,423	837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,840	177,884	0.015965	8,473	135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,076	7,259,003	0.002766	653,013	1,806	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	872	209,290	0.004166	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	34,287	356,037	0.096302	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	66,132	2,767,268	0.023898	122,657	2,931	90.00
91.00	09100	EMERGENCY	68,898	1,766,170	0.039010	1,470	57	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,913,034	0.000000	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	820,341	43,460,082		3,692,363	51,809	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	0	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	0	0	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/30/2013 1:34 pm

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)	Hospital			
					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	4,422,130	0.000000	0.000000	231,950	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	118,291	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,722,503	0.000000	0.000000	519,345	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	7,950,808	0.000000	0.000000	851,145	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	286,115	0.000000	0.000000	66,137	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,625,208	0.000000	0.000000	1,009,760	65.00
66.00	06600	PHYSICAL THERAPY	0	1,688,166	0.000000	0.000000	94,111	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0	1,277,570	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	507,622	0.000000	0.000000	59,319	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	0	222,218	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	171,654	0.000000	0.000000	22,560	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	0	125,242	0.000000	0.000000	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	893,869	0.000000	0.000000	52,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	177,884	0.000000	0.000000	8,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,259,003	0.000000	0.000000	653,013	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	209,290	0.000000	0.000000	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	356,037	0.000000	0.000000	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,767,268	0.000000	0.000000	122,657	90.00
91.00	09100	EMERGENCY	0	1,766,170	0.000000	0.000000	1,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,913,034	0.000000	0.000000	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	43,460,082			3,692,363	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/30/2013 1:34 pm

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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
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
66.01	06601 KV HEALTH & DEMOTTE PT	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701 KV HEALTH & DEMOTTE OT	0	0	0		67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801 KV HEALTH & DEMOTTE ST	0	0	0		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.03	08801 RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.686435	0	1,341,179	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.576815	0	2,971	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.593462	0	2,131,996	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.274371	0	2,417,405	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.394443	0	70,737	0	0
65.00 06500 RESPIRATORY THERAPY	0.590827	0	527,706	0	0
66.00 06600 PHYSICAL THERAPY	0.701403	0	415,150	0	0
66.01 06601 KV HEALTH & DEMOTTE PT	0.807396	0	291,525	0	0
67.00 06700 OCCUPATIONAL THERAPY	1.301417	0	71,106	0	0
67.01 06701 KV HEALTH & DEMOTTE OT	1.353986	0	53,164	0	0
68.00 06800 SPEECH PATHOLOGY	1.272129	0	30,647	0	0
68.01 06801 KV HEALTH & DEMOTTE ST	1.612662	0	12,358	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342335	0	84,330	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.436678	0	29,781	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.363135	0	2,086,262	135	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
88.03 08801 RURAL HEALTH CLINIC IV	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.502736	0	1,175,227	440	0
91.00 09100 EMERGENCY	1.110504	0	492,651	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.351526	0	1,111,077	0	0
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	12,345,272	575	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	12,345,272	575	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 1:34 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	920,632	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,714	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,265,259	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	663,266	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	27,902	0		63.00
65.00 06500 RESPIRATORY THERAPY	311,783	0		65.00
66.00 06600 PHYSICAL THERAPY	291,187	0		66.00
66.01 06601 KV HEALTH & DEMOTTE PT	235,376	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	92,539	0		67.00
67.01 06701 KV HEALTH & DEMOTTE OT	71,983	0		67.01
68.00 06800 SPEECH PATHOLOGY	38,987	0		68.00
68.01 06801 KV HEALTH & DEMOTTE ST	19,929	0		68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28,869	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13,005	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	757,595	49		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	0		88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	590,829	221		90.00
91.00 09100 EMERGENCY	547,091	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	390,572	0		92.00
93.00 04040 FAMILY PRACTICE	0	0		93.00
200.00 Subtotal (see instructions)	6,268,518	270		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	6,268,518	270		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324 Component CCN: 15Z324	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 1:34 pm
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Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.686435	0	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.576815	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.593462	0	0	0
57.00	05700 CT SCAN	0.000000	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0
60.00	06000 LABORATORY	0.274371	0	0	0
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.394443	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.590827	0	0	0
66.00	06600 PHYSICAL THERAPY	0.701403	0	0	0
66.01	06601 KV HEALTH & DEMOTTE PT	0.807396	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	1.301417	0	0	0
67.01	06701 KV HEALTH & DEMOTTE OT	1.353986	0	0	0
68.00	06800 SPEECH PATHOLOGY	1.272129	0	0	0
68.01	06801 KV HEALTH & DEMOTTE ST	1.612662	0	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342335	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.436678	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.363135	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			0
88.03	08801 RURAL HEALTH CLINIC IV	0.000000			0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			0
90.00	09000 CLINIC	0.502736	0	0	0
91.00	09100 EMERGENCY	1.110504	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.351526	0	0	0
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0
200.00	Subtotal (see instructions)		0	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0
202.00	Net Charges (line 200 +/- line 201)		0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 1:34 pm
		Component CCN: 15Z324		
		Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
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
66.01	06601	KV HEALTH & DEMOTTE PT	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
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	FAMILY PRACTICE	0	0	93.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2013 1:34 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,631	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,433	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)		3,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,014	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		184	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,034	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)		1,014	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,252,560	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)		33,350	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		818,784	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,433,776	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,129,368	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,129,368	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.097275	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)		1,005.90	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)		3,433,776	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)		774.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,575,516	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)		1,575,516	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/30/2013 1:34 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	935,470	479	1,952.96	310	605,418		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)					1,817,623		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,998,557		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)					785,434		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					785,434		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)						1,322	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						774.59	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,024,008	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 1:34 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2013 1:34 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,631	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,433	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)		3,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		184	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		244	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		141	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		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,252,560	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)		33,350	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		33,350	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,219,210	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,129,368	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,129,368	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.348263	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)		1,005.90	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)		4,219,210	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)		951.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		232,232	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)		232,232	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Date/Time Prepared: 5/30/2013 1:34 pm		Title XIX		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)	471,196	141	3,341.82	0		0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	935,470	479	1,952.96	0		0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					277,176		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					509,408		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)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,322		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					951.77		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,258,240		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet D-1
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 1:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,499,177	30.00
31.00	03100	INTENSIVE CARE UNIT		404,625	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.686435	231,950	159,219 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576815	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.593462	519,345	308,212 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.274371	851,145	233,530 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.394443	66,137	26,087 63.00
65.00	06500	RESPIRATORY THERAPY	0.590827	1,009,760	596,593 65.00
66.00	06600	PHYSICAL THERAPY	0.701403	94,111	66,010 66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0.807396	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	1.301417	59,319	77,199 67.00
67.01	06701	KV HEALTH & DEMOTTE OT	1.353986	0	0 67.01
68.00	06800	SPEECH PATHOLOGY	1.272129	22,560	28,699 68.00
68.01	06801	KV HEALTH & DEMOTTE ST	1.612662	0	0 68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342335	52,423	17,946 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436678	8,473	3,700 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363135	653,013	237,132 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		0 88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.502736	122,657	61,664 90.00
91.00	09100	EMERGENCY	1.110504	1,470	1,632 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351526	0	0 92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		3,692,363	1,817,623 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		3,692,363	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15Z324		Date/Time Prepared: 5/30/2013 1:34 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.686435	11,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576815	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.593462	29,263	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.274371	101,148	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.394443	11,698	63.00
65.00	06500	RESPIRATORY THERAPY	0.590827	271,692	65.00
66.00	06600	PHYSICAL THERAPY	0.701403	91,584	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0.807396	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.301417	76,360	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	1.353986	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.272129	14,725	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	1.612662	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342335	3,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436678	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363135	153,529	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.502736	8,148	90.00
91.00	09100	EMERGENCY	1.110504	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351526	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		773,032	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)		773,032	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 1:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		164,176	30.00
31.00	03100	INTENSIVE CARE UNIT		25,231	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.686435	104,729	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.576815	38,438	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.593462	48,142	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.274371	100,675	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.394443	10,957	63.00
65.00	06500	RESPIRATORY THERAPY	0.590827	40,067	65.00
66.00	06600	PHYSICAL THERAPY	0.701403	6,388	66.00
66.01	06601	KV HEALTH & DEMOTTE PT	0.807396	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.301417	0	67.00
67.01	06701	KV HEALTH & DEMOTTE OT	1.353986	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.272129	0	68.00
68.01	06801	KV HEALTH & DEMOTTE ST	1.612662	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.342335	24,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.436678	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.363135	117,220	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.648641	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	1.546811	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.502736	10,682	90.00
91.00	09100	EMERGENCY	1.110504	12,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.351526	69,735	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		584,110	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)		584,110	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,268,788 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)			6,268,788 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			6,331,476 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)			30,083 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,966,185 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)			4,335,208 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)			4,335,208 30.00
31.00	Primary payer payments			2,228 31.00
32.00	Subtotal (line 30 minus line 31)			4,332,980 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)			94,317 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			94,317 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,334 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,427,297 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)			4,427,297 40.00
41.00	Interim payments			4,940,398 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)			-513,101 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: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,783,095		4,556,598	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/04/2012	158,800	09/04/2012	383,800	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)		158,800		383,800	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)		3,941,895		4,940,398	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		331,966		513,101	6.02	
7.00	Total Medicare program liability (see instructions)		3,609,929		4,427,297	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: 151324
Component CCN: 15Z324

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,189,338		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,189,338		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		67,717		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,257,055		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,010 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,344 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			162 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,590 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			49,868,062 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			118,385 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet E-2	
		Component CCN: 15Z324		Date/Time Prepared: 5/30/2013 1:34 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		793,288	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)		466,224	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,014	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,259,512	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,259,512	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,259,512	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		2,457	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,257,055	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		1,257,055	0	19.00
20.00	Interim payments		1,189,338	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)		67,717	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part V Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		3,998,557	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)		3,998,557	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,038,543	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)		4,038,543	19.00
20.00	Deductibles (exclude professional component)		483,465	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,555,078	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,555,078	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		54,851	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		54,851	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26,131	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,609,929	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)		3,609,929	30.00
31.00	Interim payments		3,941,895	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)		-331,966	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2013 1:34 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		509,408		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		509,408	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		509,408	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		189,407		8.00
9.00	Ancillary service charges		584,110	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		773,517	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		773,517	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		264,109	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		509,408	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		509,408	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		509,408	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		509,408	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		509,408	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		509,408	0	40.00
41.00	Interim payments		566,179	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-56,771	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/30/2013 1:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,549,707	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	6,823,804	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,274,938	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)	9,648,449	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	22,449,432	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,449,432	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	2,340,894	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,340,894	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,438,775	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,803,901	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,053,148	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	797,408	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,654,457	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	15,408,616	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,408,616	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,063,073	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,375,702				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)	14,375,702	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,438,775	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/30/2013 1:34 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		13,143,923		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,231,779			2.00
3.00	Total (sum of line 1 and line 2)		14,375,702		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		14,375,702		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,375,702		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: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,048,482		3,048,482	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	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,048,482		3,048,482	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	624,560		624,560	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)	624,560		624,560	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,673,042		3,673,042	17.00
18.00	Ancillary services	7,009,870	26,783,511	33,793,381	18.00
19.00	Outpatient services	581,369	6,865,103	7,446,472	19.00
20.00	RURAL HEALTH CLINIC	0	209,290	209,290	20.00
20.03	RURAL HEALTH CLINIC IV	0	356,037	356,037	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,850,052	1,850,052	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	0	1,237,019	1,237,019	26.00
27.00	OTHER OUTPATIENT SERVICES AND PRO FE	818,934	3,695,226	4,514,160	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,083,215	40,996,238	53,079,453	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,279,867		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,279,867		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151324

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/30/2013 1:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,079,453	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,612,066	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,467,387	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,279,867	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-812,480	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	873,187	24.00
24.01	INVESTMENT INCOME	4,504	24.01
24.02	OTHER NON OPERATING INCOME	1,154,918	24.02
24.03	LTC INCOME	11,650	24.03
25.00	Total other income (sum of lines 6-24)	2,044,259	25.00
26.00	Total (line 5 plus line 25)	1,231,779	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,231,779	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet H

HHA CCN: 157149

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	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	321,983	0	0	351,175	673,158	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	609,220	0	0	0	609,220	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	5,264	0	0	0	5,264	10.00
11.00	Home Health Aide	282,804	0	0	0	282,804	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,219,271	0	0	351,175	1,570,446	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	-159,051	514,107	0	514,107		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	609,220	0	609,220		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	5,264	0	5,264		10.00
11.00	Home Health Aide	0	282,804	0	282,804		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)	-159,051	1,411,395	0	1,411,395		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet H-1 Part I Date/Time Prepared: 5/30/2013 1:34 pm
		HHA CCN: 157149	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	514,107	0	0	0	514,107	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	609,220	0	0	0	609,220	6.00	
7.00	Physical Therapy	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	5,264	0	0	0	5,264	10.00	
11.00	Home Health Aide	282,804	0	0	0	282,804	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,411,395	0	0	0	1,411,395	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	514,107					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	349,056	958,276				6.00	
7.00	Physical Therapy	0	0				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	3,016	8,280				10.00	
11.00	Home Health Aide	162,035	444,839				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)		1,411,395				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2012 To 12/31/2012	Worksheet H-1 Part II Date/Time Prepared: 5/30/2013 1:34 pm PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-514,107	897,288
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	609,220
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	5,264
11.00	Home Health Aide	0	0	0	0	0	282,804
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-514,107	897,288
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		514,107
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.572957

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet H-2

HHA CCN: 157149

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	37,586		331,493	369,079	76,136	43,777	1.00
2.00 Skilled Nursing Care	958,276	0		0	958,276	197,679	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	8,280	0		0	8,280	1,708	0	6.00
7.00 Home Health Aide	444,839	0		0	444,839	91,764	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)	1,411,395	37,586		331,493	1,780,474	367,287	43,777	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000			21.00

Cost Center Description	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	18,761	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	18,761	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

Period: From 01/01/2012 To 12/31/2012

Worksheet H-2 Part I

HHA CCN: 157149

Date/Time Prepared: 5/30/2013 1:34 pm

Home Health Agency I

PPS

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		15.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	507,753	0	507,753	1.00
2.00	Skilled Nursing Care	0	0	0	1,155,955	0	1,155,955	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	9,988	0	9,988	6.00
7.00	Home Health Aide	0	0	0	536,603	0	536,603	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	2,210,299	0	2,210,299	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		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	344,742	1,500,697					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	2,979	12,967					6.00
7.00	Home Health Aide	160,032	696,635					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)	507,753	2,210,299					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.	0.298232						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: 151324

Period: From 01/01/2012 To 12/31/2012

Worksheet H-2 Part II Date/Time Prepared: 5/30/2013 1:34 pm

HHA CCN: 157149

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00						
1.00 Administrative and General	3,086	1,219,270	5A	0	369,079	3,086	0	1.00
2.00 Skilled Nursing Care	0	0		0	958,276	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	8,280	0	0	6.00
7.00 Home Health Aide	0	0		0	444,839	0	0	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	0	8.00
9.00 Drugs	0	0		0	0	0	0	9.00
10.00 DME	0	0		0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	0	13.00
14.00 Clinic	0	0		0	0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,086	1,219,270		0	1,780,474	3,086	0	20.00
21.00 Total cost to be allocated	37,586	331,493		0	367,287	43,777	0	21.00
22.00 Unit cost multiplier	12.179520	0.271878		0	0.206286	14.185677	0.000000	22.00
Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)		
	9.00	10.00	11.00	13.00	14.00	15.00		
1.00 Administrative and General	3,400	0	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	3,400	0	0	0	0	0	20.00	
21.00 Total cost to be allocated	18,761	0	0	0	0	0	21.00	
22.00 Unit cost multiplier	5.517941	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151324
HHA CCN: 157149

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	16.00	17.00		
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: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part I Date/Time Prepared: 5/30/2013 1:34 pm
		HHA CCN: 157149	Title XVIII	Home Health Agency I

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	1,500,697		1,500,697	5,473	274.20	1.00
2.00	Physical Therapy	3.00	0	276,746	276,746	2,740	101.00	2.00
3.00	Occupational Therapy	4.00	0	199,773	199,773	1,066	187.40	3.00
4.00	Speech Pathology	5.00	0	62,900	62,900	319	197.18	4.00
5.00	Medical Social Services	6.00	12,967		12,967	36	360.19	5.00
6.00	Home Health Aide	7.00	696,635		696,635	7,441	93.62	6.00
7.00	Total (sum of lines 1-6)		2,210,299	539,419	2,749,718	17,075		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		5.00
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation

8.00	Skilled Nursing Care		23844	1,092	1,518			8.00
8.01	Skilled Nursing Care		29140	5	0			8.01
8.02	Skilled Nursing Care		99915	50	44			8.02
9.00	Physical Therapy		23844	1,004	725			9.00
9.01	Physical Therapy		29140	14	0			9.01
9.02	Physical Therapy		99915	48	40			9.02
10.00	Occupational Therapy		23844	478	236			10.00
10.01	Occupational Therapy		29140	7	0			10.01
10.02	Occupational Therapy		99915	9	1			10.02
11.00	Speech Pathology		23844	136	9			11.00
11.01	Speech Pathology		29140	0	0			11.01
11.02	Speech Pathology		99915	1	0			11.02
12.00	Medical Social Services		23844	7	13			12.00
12.01	Medical Social Services		29140	0	0			12.01
12.02	Medical Social Services		99915	1	0			12.02
13.00	Home Health Aide		23844	464	1,904			13.00
13.01	Home Health Aide		29140	0	0			13.01
13.02	Home Health Aide		99915	7	48			13.02
14.00	Total (sum of lines 8-13)			3,323	4,538			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	8,333	8,333	24,342	0.342330	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B		Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	1,147	1,562		314,507	428,300		1.00
2.00	Physical Therapy	1,066	765		107,666	77,265		2.00
3.00	Occupational Therapy	494	237		92,576	44,414		3.00
4.00	Speech Pathology	137	9		27,014	1,775		4.00
5.00	Medical Social Services	8	13		2,882	4,682		5.00
6.00	Home Health Aide	471	1,952		44,095	182,746		6.00
7.00	Total (sum of lines 1-6)	3,323	4,538		588,740	739,182		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet H-3

HHA CCN: 157149

To 12/31/2012

Part I
Date/Time Prepared:
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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies		0	0		0		15.00
16.00	Cost of Drugs							16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	742,807						1.00
2.00	Physical Therapy	184,931						2.00
3.00	Occupational Therapy	136,990						3.00
4.00	Speech Pathology	28,789						4.00
5.00	Medical Social Services	7,564						5.00
6.00	Home Health Aide	226,841						6.00
7.00	Total (sum of lines 1-6)	1,327,922						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324

Period:

Worksheet H-3

HHA CCN: 157149

From 01/01/2012

Part II

To 12/31/2012

Date/Time Prepared:

Title XVIII

Home Health Agency I

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.701403	394,560	276,746	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.807396	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy	67.00	1.301417	153,504	199,773	col. 2, line 3.00		2.00
2.01 Occupational Therapy 1	67.01	1.353986	0	0	col. 2, line 3.01		2.01
3.00 Speech Pathology	68.00	1.272129	49,445	62,900	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	1.612662	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.342335	24,342	8,333	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.363135	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2013 1:34 pm	
		Title XVII I	Home Health Agency I	PPS	
		Part A	Part B		
		1.00	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	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		0	0	0 2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	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)		0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	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	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		489,306	440,985	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		18,189	24,739	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		8,009	5,835	13.00
14.00	Total PPS Reimbursement - PEP Episodes		2,231	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		3,869	12,921	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)		521,604	484,480	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		521,604	484,480	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		521,604	484,480	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: 151324 HHA CCN: 157149	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2013 1:34 pm	
		Title XVIII	Home Health Agency I	PPS	
			Part A Services	Part B Services	
			1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)		521,604	484,480	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		521,604	484,480	31.00
32.00	Interim payments (see instructions)		521,604	484,480	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. 15-11, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324	Period: From 01/01/2012	Worksheet H-5
	HHA CCN: 157149	To 12/31/2012	
		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		521,604		484,480	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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)		521,604		484,480	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)		521,604		484,480	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/30/2013 1:34 pm PPS
			Home Health Agency I	
			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: 151324

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151519

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

		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	15,880	0	0	0	170,308	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	37,393	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	100,007	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	5,772	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	Total (sum of lines 1 thru 38)	159,052	0	0	0	170,308	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K

Hospice CCN: 151519

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

		Hospice I					
		Total (col. 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	186,188	159,051	345,239	0	345,239	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	37,393	0	37,393	0	37,393	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	100,007	0	100,007	0	100,007	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	5,772	0	5,772	0	5,772	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	Total (sum of lines 1 thru 38)	329,360	159,051	488,411	0	488,411	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151519

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

		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	15,880	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	37,393	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	100,007	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)	53,273	0	100,007	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-1

Hospice CCN: 151519

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

		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	3.00
4.00	Transportation - Staff		0	0	4.00
5.00	Volunteer Service Coordination		0	0	5.00
6.00	Administrative and General		0	0	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	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	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		5,772	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				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	27.00
28.00	Imaging Services		0	0	28.00
29.00	Labs and Diagnostics		0	0	29.00
30.00	Medical Supplies		0	0	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	Total (sum of lines 1 thru 38)	0	5,772	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-4

Hospice CCN: 151519

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
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	345,239	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	37,393	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	100,007	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	5,772	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	Total (sum of lines 1 thru 38)	488,411	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet K-4 Part I Date/Time Prepared: 5/30/2013 1:34 pm
		Hospice CCN: 151519	Hospice I	

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 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	345,239	345,239	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	37,393	90,168	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	100,007	241,153	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	5,772	13,918	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	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	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	488,411	488,411	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-4

Hospice CCN: 151519

To 12/31/2012

Part II
Date/Time Prepared:
5/30/2013 1:34 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		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: 151324

Period:

Worksheet K-4

Hospice CCN: 151519

From 01/01/2012
To 12/31/2012

Part II
Date/Time Prepared:
5/30/2013 1:34 pm

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	-345,239	143,172	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	37,393	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	100,007	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	5,772	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	0	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	0	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)		345,239	39.00
40.00	Unit Cost Multiplier		2.411358	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151519

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	
		NEW BLDG & FIXT	1.00				
1.00 Administrative and General	0	3,033		43,242	46,275	9,546	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	127,561	0		0	127,561	26,314	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	341,160	0		0	341,160	70,376	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	19,690	0		0	19,690	4,062	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)	488,411	3,033		43,242	534,686	110,298	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 01/01/2012
To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 11.00	
1.00	Administrative and General	3,532	0	0	0	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)	3,532	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 01/01/2012
To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	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)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-5

Hospice CCN: 151519

To 12/31/2012

Part I
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	59,353					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	153,875	0	153,875	15,502	169,377	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	411,536	0	411,536	41,458	452,994	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	23,752	0	23,752	2,393	26,145	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)	648,516	0	648,516		648,516	34.00
35.00	Unit Cost Multiplier (see instructions)				0.100741		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324
Hospice CCN: 151519

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)						
		1.00		4.00	5A	5.00	7.00	
1.00	Administrative and General	249		159,051	0	46,275	249	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	127,561	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	341,160	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	19,690	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)	249		159,051		534,686	249	34.00
35.00	Total cost to be allocated	3,033		43,242		110,298	3,532	35.00
36.00	Unit Cost Multiplier (see instructions)	12.180723		0.271875		0.206286	14.184739	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Hospice CCN: 151519

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	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)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Hospice CCN: 151519

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2013 1:34 pm

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151324 Hospice CCN: 151519		Period: From 01/01/2012 To 12/31/2012		Worksheet K-5 Part III Date/Time Prepared: 5/30/2013 1:34 pm	
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		
ANCI LLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.701403	0	0	1.00	
1.01	KV HEALTH & DEMOTTE PT	66.01	0.807396	0	0	1.01	
2.00	OCCUPATIONAL THERAPY	67.00	1.301417	0	0	2.00	
2.01	KV HEALTH & DEMOTTE OT	67.01	1.353986	0	0	2.01	
3.00	SPEECH PATHOLOGY	68.00	1.272129	0	0	3.00	
3.01	KV HEALTH & DEMOTTE ST	68.01	1.612662	0	0	3.01	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.363135	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00	
6.00	LABORATORY	60.00	0.274371	0	0	6.00	
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01	
7.00	MEDI CAL SUPPLI ES CHARGED TO PATIENTS	71.00	0.342335	0	0	7.00	
8.00	FAMI LY PRACTI CE	93.00	0.000000	0	0	8.00	
9.00	RADI OLOGY-THERAPEUTI C	55.00				9.00	
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00				10.00	
11.00	Totals (sum of lines 1-10)				0	11.00	

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151324

Period: From 01/01/2012

Worksheet K-6

Hospice CCN: 151519

To 12/31/2012

Date/Time Prepared: 5/30/2013 1:34 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				648,516	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6,604	2.00
3.00	Average cost per diem (line 1 divided by line 2)				98.20	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	6,009				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	590,084				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		66			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		6,481			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	1,474				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	144,747				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		1,228			10.00
11.00	Aggregate NF cost (line 3 times line 10)		120,590			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			529		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			51,948		13.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/30/2013 1:34 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	50,598	0	50,598	0	50,598	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	33,700	0	33,700	0	33,700	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	84,298	0	84,298	0	84,298	10.00
11.00	Physician Services Under Agreement	0	39,541	39,541	0	39,541	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	39,541	39,541	0	39,541	14.00
15.00	Medical Supplies	0	15,318	15,318	0	15,318	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	15,318	15,318	0	15,318	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	84,298	54,859	139,157	0	139,157	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	71,789	38,540	110,329	0	110,329	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	71,789	38,540	110,329	0	110,329	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	156,087	93,399	249,486	0	249,486	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/30/2013 1:34 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	50,598
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	33,700
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	84,298
11.00	Physician Services Under Agreement	0	39,541
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	39,541
15.00	Medical Supplies	0	15,318
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	15,318
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	139,157
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-5,885	104,444
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,885	104,444
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,885	243,601

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/30/2013 1:34 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) IV Reclassifications	Cost	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	0	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	0	2.00
3.00	Nurse Practitioner	98,498	0	98,498	0	98,498	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	0	4.00
5.00	Other Nurse	81,706	0	81,706	0	81,706	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	180,204	0	180,204	0	180,204	0	10.00
11.00	Physician Services Under Agreement	0	64,956	64,956	0	64,956	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	64,956	64,956	0	64,956	0	14.00
15.00	Medical Supplies	0	21,656	21,656	0	21,656	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,656	21,656	0	21,656	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	180,204	86,612	266,816	0	266,816	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	0	28.00
FACILITY OVERHEAD								
29.00	Facility Costs	0	0	0	0	0	0	29.00
30.00	Administrative Costs	36,775	30,521	67,296	0	67,296	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,775	30,521	67,296	0	67,296	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	216,979	117,133	334,112	0	334,112	0	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/30/2013 1:34 pm
		Rural Health Clinic (RHC) IV	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	98,498
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	81,706
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	180,204
11.00	Physician Services Under Agreement	0	64,956
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	64,956
15.00	Medical Supplies	0	21,656
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	21,656
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	266,816
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	67,296
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	67,296
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	334,112

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-2 Date/Time Prepared: 5/30/2013 1:34 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	2,252	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	1.00	2,252		2,100	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.00	2,252			8.00
9.00	Physician Services Under Agreements		925		925	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)				139,157	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)				139,157	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)				104,444	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				101,443	15.00
16.00	Total overhead (sum of lines 14 and 15)				205,887	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				205,887	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				205,887	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				345,044	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet M-2
		Component CCN: 158502		Date/Time Prepared: 5/30/2013 1:34 pm
			Rural Health Clinic (RHC) IV	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	4,564	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	1.00	4,564		2,100	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.00	4,564			8.00
9.00	Physician Services Under Agreements		494		494	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)		266,816
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		266,816
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)		67,296
15.00	Parent provider overhead allocated to facility (see instructions)		216,610
16.00	Total overhead (sum of lines 14 and 15)		283,906
17.00	Allowable GME overhead (see instructions)		0
18.00	Subtract line 17 from line 16		283,906
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		283,906
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		550,722

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-3 Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		345,044	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		479	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		344,565	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,252	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		925	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,177	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		108.46	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	108.46	108.46	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	130	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	14,100	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) *		14,100	16.00
16.01	Total program charges (see instructions)(from contractor's records)		10,019	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		90	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		127	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.)		8,890	16.04
16.05	Total program cost (see instructions)		9,017	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,861	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		9,017	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		479	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		9,496	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)		9,496	26.00
27.00	Interim payments		6,449	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)		3,047	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet M-3
		Component CCN: 158502		Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Rural Health Clinic (RHC) IV	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)		550,722	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,973	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		545,749	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,564	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		494	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,058	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		107.90	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	107.90	107.90	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	771	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	83,191	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) *		83,191	16.00
16.01	Total program charges (see instructions)(from contractor's records)		60,872	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		320	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		437	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.)		55,414	16.04
16.05	Total program cost (see instructions)		55,851	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,486	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		55,851	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,595	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		60,446	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)		60,446	26.00
27.00	Interim payments		53,009	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)		7,437	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: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-4 Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	84,298	84,298	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000668	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	56	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	137	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	193	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	139,157	139,157	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	205,887	205,887	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001387	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	286	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	479	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	10	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	47.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	10	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	479	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)		479	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)		479	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324	Period: From 01/01/2012 To 12/31/2012	Worksheet M-4
		Component CCN: 158502		Date/Time Prepared: 5/30/2013 1:34 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	180,204	180,204	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000258	0.003391	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	46	611	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	666	1,086	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	712	1,697	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	266,816	266,816	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	283,906	283,906	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002669	0.006360	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	758	1,806	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,470	3,503	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	6	79	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	245.00	44.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	76	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,225	3,370	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)		4,973	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)		4,595	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2012 To 12/31/2012	Worksheet M-5 Date/Time Prepared: 5/30/2013 1:34 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		6,449	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		6,449	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		3,047	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		9,496	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2012 To 12/31/2012	Worksheet M-5 Date/Time Prepared: 5/30/2013 1:34 pm
		Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		53,009	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		53,009	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		7,437	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		60,446	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00