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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140001	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/22/2013 10:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2013 Time: 10:23 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRAHAM HOSPITAL ASSOCIATION (140001) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-574,975	-1,250	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	210,620	134		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	1	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		142,811		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-364,354	141,696	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2013 9:42 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 210 WEST WALNUT	PO Box:			1.00
2.00	City: CANTON	State: IL	Zip Code: 61520-	County: FULTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GRAHAM HOSPITAL HOME HEALTH AGENCY	147142	99914		06/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GRAHAM HOSPITAL HOSPICE	141558	99914		07/28/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,502	0	0	0	110	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 9:42 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	07/01/2012	06/30/2013	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Y	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140001	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 9:42 am

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.					109.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	775,045	118.01

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

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		1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:		Contractor's Number:	141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:		Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2013 9:42 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		Y	Y	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.		Y		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.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/09/2012	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: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADRY, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	10/09/2012			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

HFS Supplemental Information | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part IX | Date/Time Prepared: 11/22/2013 9:42 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2013 9:42 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	44	14,751	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		44	14,751	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	2,012	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		49	16,763	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	32	11,680		0	19.00
20.00	NURSING FACILITY	45.00	18	6,570		0	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
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		99				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2013 9:42 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,153	1,055	6,454			1.00
2.00	HMO and other (see instructions)	1,164	110				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,153	1,055	6,454			7.00
8.00	INTENSIVE CARE UNIT	350	71	828			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		376	573			13.00
14.00	Total (see instructions)	3,503	1,502	7,855	0.00	479.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,354	81	4,854	0.00	24.19	19.00
20.00	NURSING FACILITY		5,115	6,173	0.00	17.59	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,025	416	5,257	0.00	10.28	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	5.32	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	17,796	0	94,841	0.00	63.50	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	600.23	27.00
28.00	Observation Bed Days		0	981			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			160			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2013 9:42 am

	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)(see instructions for col. 2 for the portion of LDP room available beds)		0	941	409	2,177	1.00
2.00	HMO and other (see instructions)			301			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	941	409	2,177	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					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
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2013 9:42 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	28,867,350	0	28,867,350	1,248,508.00	23.12	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,104,621	0	1,104,621	10,280.00	107.45	3.00
4.00	Physician-Part A - Administrative		19,773	0	19,773	86.00	229.92	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,049,222	0	2,049,222	23,718.00	86.40	5.00
6.00	Non-physician-Part B		2,051,183	0	2,051,183	120,135.00	17.07	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,026,211	0	1,026,211	50,321.00	20.39	9.00
10.00	Excluded area salaries (see instructions)		2,342,752	87,751	2,430,503	112,012.00	21.70	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		524,171	0	524,171	10,224.34	51.27	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,583,065	0	5,583,065			17.00
18.00	Wage-related costs (other) (see instructions)		114,650	0	114,650			18.00
19.00	Excluded areas		954,406	0	954,406			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		130,127	0	130,127			21.00
22.00	Physician Part A - Administrative		17,425	0	17,425			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		271,011	0	271,011			23.00
24.00	Wage-related costs (RHC/FQHC)		654,680	0	654,680			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	162,937	0	162,937	8,253.00	19.74	26.00
27.00	Administrative & General	5.00	5,702,790	0	5,702,790	248,969.00	22.91	27.00
28.00	Administrative & General under contract (see inst.)		120,655	0	120,655	1,058.00	114.04	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	791,083	-1,488	789,595	49,389.00	15.99	30.00
31.00	Laundry & Linen Service	8.00	26,493	0	26,493	2,364.00	11.21	31.00
32.00	Housekeeping	9.00	668,204	0	668,204	58,146.00	11.49	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	663,450	-381,153	282,297	23,015.00	12.27	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	381,153	381,153	31,075.00	12.27	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	490,891	0	490,891	15,324.00	32.03	38.00
39.00	Central Services and Supply	14.00	49,830	0	49,830	4,181.00	11.92	39.00
40.00	Pharmacy	15.00	621,954	0	621,954	25,486.00	24.40	40.00
41.00	Medical Records & Medical Records Library	16.00	434,552	0	434,552	39,579.00	10.98	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2013 9:42 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2013 9:42 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		23,782,979	0	23,782,979	1,095,433.00	21.71	1.00
2.00	Excluded area salaries (see instructions)		3,368,963	87,751	3,456,714	162,333.00	21.29	2.00
3.00	Subtotal salaries (line 1 minus line 2)		20,414,016	-87,751	20,326,265	933,100.00	21.78	3.00
4.00	Subtotal other wages & related costs (see inst.)		524,171	0	524,171	10,224.34	51.27	4.00
5.00	Subtotal wage-related costs (see inst.)		5,715,140	0	5,715,140	0.00	28.12	5.00
6.00	Total (sum of lines 3 thru 5)		26,653,327	-87,751	26,565,576	943,324.34	28.16	6.00
7.00	Total overhead cost (see instructions)		9,732,839	-1,488	9,731,351	506,839.00	19.20	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part IV | Date/Time Prepared: 11/22/2013 9:42 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	627,383	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	10,000	6.00
7.00	Employee Managed Care Program Administration Fees	251,530	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,009,675	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	19,627	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	125,691	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	274,881	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,988,696	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	70,781	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	8,313	22.00
23.00	Tuition Reimbursement	224,921	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,611,498	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	114,650	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part V | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	524,170	0	1.00
2.00	Hospital	320,937	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	162,207	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	41,026	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140001 | Component CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-4 | Date/Time Prepared: 11/22/2013 9:42 am

Home Health Agency I | PPS

						1.00	
0.00	County				MCLEAN		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	1,913	293	1,410	3,616	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	158.00	21.00	80.00	259.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.49	0.00	0.49	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.55	0.00	2.55	5.00
6.00	Direct Nursing Service			4.40	0.00	4.40	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.56	0.31	0.87	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.09	0.04	0.13	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.42	0.00	0.42	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.74	0.00	1.74	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			0.03	0.00	0.03	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).			99914			20.00
20.01				37900			20.01
20.02				44100			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,928	32	155	5	2,120	21.00
22.00	Skilled Nursing Visit Charges	342,213	5,704	27,534	891	376,342	22.00
23.00	Physical Therapy Visits	349	0	43	0	392	23.00
24.00	Physical Therapy Visit Charges	67,188	0	8,331	0	75,519	24.00
25.00	Occupational Therapy Visits	69	0	0	0	69	25.00
26.00	Occupational Therapy Visit Charges	13,266	0	0	0	13,266	26.00
27.00	Speech Pathology Visits	4	0	0	0	4	27.00
28.00	Speech Pathology Visit Charges	775	0	0	0	775	28.00
29.00	Medical Social Service Visits	13	0	0	0	13	29.00
30.00	Medical Social Service Visit Charges	3,182	0	0	0	3,182	30.00
31.00	Home Health Aide Visits	424	0	3	0	427	31.00
32.00	Home Health Aide Visit Charges	46,950	0	335	0	47,285	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,787	32	201	5	3,025	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	473,574	5,704	36,200	891	516,369	35.00
36.00	Total Number of Episodes (standard/non outlier)	198		74	1	273	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	32,074	751	10,556	67	43,448	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/22/2013 9:42 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	14	0	14	7.00
8.00		RHL	11	0	11	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	52	0	52	12.00
13.00		RUB	33	0	33	13.00
14.00		RUA	176	0	176	14.00
15.00		RVC	221	0	221	15.00
16.00		RVB	34	0	34	16.00
17.00		RVA	701	0	701	17.00
18.00		RHC	250	0	250	18.00
19.00		RHB	225	0	225	19.00
20.00		RHA	973	0	973	20.00
21.00		RMC	116	0	116	21.00
22.00		RMB	46	0	46	22.00
23.00		RMA	212	0	212	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	2	0	2	32.00
33.00		HC2	11	0	11	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	75	0	75	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	3	0	3	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	15	0	15	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	12	0	12	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	15	0	15	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	28	0	28	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	125	0	125	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/22/2013 9:42 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,354	0	3,354	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99916	99916	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,026,211	53.01	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	1,716	0.09	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,935,926			207.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 11/22/2013 9:42 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			180 S MAIN STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	CANTON		IL	61520	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	0830	1500	0730	1730	0730	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	4	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	FARMINGTON CLINIC	143494	14.00
14.01		CANTON CLINIC	143492	14.01
14.02		CUBA CLINIC	143497	14.02
14.03		COLEMAN CLINIC	143493	14.03

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

			County			
			4.00			
2.00	City, State, Zip Code, County	FULTON				2.00

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

Provider CCN: 140001 Component CCN: 143493

Period: From 07/01/2012 To 06/30/2013

Worksheet S-8

Date/Time Prepared: 11/22/2013 9:42 am

Rural Health Clinic (RHC) I

Cost

		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	1730	0730	1730	0730	1730	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	0730	1730	0830	1700		11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140001 Component CCN: 141558	Period: From 07/01/2012 To 06/30/2013	Worksheet S-9 Parts I & II Date/Time Prepared: 11/22/2013 9:42 am
		Hospice I	

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	2,579	310	0	0	551	3,440	2.00
3.00	Inpatient Respite Care	18	0	0	0	0	18	3.00
4.00	General Inpatient Care	12	0	0	0	10	22	4.00
5.00	Total Hospice Days	2,609	310	0	0	561	3,480	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	78	5	0	0	9	92	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	33.45	62.00	0.00	0.00	62.33	37.83	8.00
9.00	Unduplicated Census Count	76	5	0	0	9	90	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 11/22/2013 9:42 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.378632	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,125,784	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,089,678	5.00
6.00	Medicaid charges	30,163,971	6.00
7.00	Medicaid cost (line 1 times line 6)	11,421,045	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)	3,205,583	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)	3,205,583	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,725,242	548,601	6,273,843	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,167,760	207,718	2,375,478	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,167,760	207,718	2,375,478	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,515,420	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	207,419	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	4,308,001	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,631,147	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	4,006,625	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,212,208	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,574,145	6,574,145	-2,705,929	3,868,216	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		0	0	28,285	28,285	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,687,085	2,687,085	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	162,937	7,805,319	7,968,256	21,749	7,990,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,702,790	5,958,917	11,661,707	-182,245	11,479,462	5.00
7.00	00700	OPERATION OF PLANT	791,083	1,887,208	2,678,291	-1,488	2,676,803	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,493	228,487	254,980	0	254,980	8.00
9.00	00900	HOUSEKEEPING	668,204	139,026	807,230	0	807,230	9.00
10.00	01000	DIETARY	663,450	702,124	1,365,574	-784,524	581,050	10.00
11.00	01100	CAFETERIA	0	0	0	784,524	784,524	11.00
13.00	01300	NURSING ADMINISTRATION	490,891	8,276	499,167	0	499,167	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,830	363,190	413,020	-599,117	-186,097	14.00
15.00	01500	PHARMACY	621,954	87,659	709,613	0	709,613	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	434,552	83,949	518,501	0	518,501	16.00
20.00	02000	NURSING SCHOOL	912,954	192,454	1,105,408	101,561	1,206,969	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,486,405	151,880	2,638,285	0	2,638,285	30.00
31.00	03100	INTENSIVE CARE UNIT	524,275	36,451	560,726	0	560,726	31.00
43.00	04300	NURSERY	287,052	7,004	294,056	0	294,056	43.00
44.00	04400	SKILLED NURSING FACILITY	1,026,211	48,750	1,074,961	0	1,074,961	44.00
45.00	04500	NURSING FACILITY	612,457	15,462	627,919	0	627,919	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,470,756	2,360,262	3,831,018	-1,692,163	2,138,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,623	0	77,623	0	77,623	52.00
53.00	05300	ANESTHESIOLOGY	1,104,621	74,478	1,179,099	0	1,179,099	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,967	815,107	1,677,074	0	1,677,074	54.00
57.00	05700	CT SCAN	53,348	179,775	233,123	0	233,123	57.00
58.00	05800	MRI	50,960	121,731	172,691	0	172,691	58.00
60.00	06000	LABORATORY	1,450,094	1,962,351	3,412,445	0	3,412,445	60.00
65.00	06500	RESPIRATORY THERAPY	427,538	72,029	499,567	0	499,567	65.00
66.00	06600	PHYSICAL THERAPY	511,974	611,473	1,123,447	0	1,123,447	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,025,432	1,025,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,265,848	1,265,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,650,824	1,650,824	0	1,650,824	73.00
76.97	07697	CARDIAC REHABILITATION	227,089	36,575	263,664	0	263,664	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,810,976	7,710,866	10,521,842	-212,161	10,309,681	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,102,623	248,447	3,351,070	0	3,351,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	438,902	648,728	1,087,630	30,743	1,118,373	96.00
101.00	10100	HOME HEALTH AGENCY	578,782	111,164	689,946	4,909	694,855	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	186,165	85,702	271,867	4,909	276,776	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,814,956	40,979,813	69,794,769	-222,582	69,572,187	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	52,394	285,353	337,747	213,649	551,396	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	8,933	8,933	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	1,955	1,955	0	1,955	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118-199)	28,867,350	41,267,121	70,134,471	0	70,134,471	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,117,649	2,750,567		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	28,285		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,669	2,685,416		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,799,244	5,190,761		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,513,239	9,966,223		5.00
7.00	00700	OPERATION OF PLANT	0	2,676,803		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,980		8.00
9.00	00900	HOUSEKEEPING	-2,250	804,980		9.00
10.00	01000	DIETARY	-29,930	551,120		10.00
11.00	01100	CAFETERIA	-413,784	370,740		11.00
13.00	01300	NURSING ADMINISTRATION	-3,673	495,494		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-186,097		14.00
15.00	01500	PHARMACY	-285,170	424,443		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,588	496,913		16.00
20.00	02000	NURSING SCHOOL	-682,875	524,094		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-40	2,638,245		30.00
31.00	03100	INTENSIVE CARE UNIT	0	560,726		31.00
43.00	04300	NURSERY	0	294,056		43.00
44.00	04400	SKILLED NURSING FACILITY	16,502	1,091,463		44.00
45.00	04500	NURSING FACILITY	9,855	637,774		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,138,855		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	77,623		52.00
53.00	05300	ANESTHESIOLOGY	-1,104,220	74,879		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-55,553	1,621,521		54.00
57.00	05700	CT SCAN	-2,848	230,275		57.00
58.00	05800	MRI	0	172,691		58.00
60.00	06000	LABORATORY	-114,030	3,298,415		60.00
65.00	06500	RESPIRATORY THERAPY	0	499,567		65.00
66.00	06600	PHYSICAL THERAPY	0	1,123,447		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,025,432		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,265,848		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,650,824		73.00
76.97	07697	CARDIAC REHABILITATION	-9,163	254,501		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-131,972	10,177,709		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-2,084,585	1,266,485		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-77,048	1,041,325		96.00
101.00	10100	HOME HEALTH AGENCY	-973	693,882		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	276,776		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,425,146	59,147,041		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	551,396		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	NONPAID WORKERS	0	0		193.01
193.02	19302	FOUNDATION	0	0		193.02
194.00	07950	PHYSICIANS CLINIC	0	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0		194.02
194.03	07953	RUCHFORD POB	0	8,933		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0		194.04
194.05	07955	FARMINGTON POB	0	0		194.05
194.06	07956	LEWISTON POB	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	1,955		194.07
194.08	07958	KELLEY HOME	0	0		194.08
200.00		TOTAL (SUM OF LINES 118-199)	-10,425,146	59,709,325		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	00101		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	NONPAID WORKERS	19301		193.01
193.02	FOUNDATION	19302		193.02
194.00	PHYSICIANS CLINIC	07950		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	07951		194.01
194.02	ST. FRANCIS RENAL DIALYSIS	07952		194.02
194.03	RUCHFORD POB	07953		194.03
194.04	EP COLEMAN RENTAL SPACE	07954		194.04
194.05	FARMINGTON POB	07955		194.05
194.06	LEWISTON POB	07956		194.06
194.07	OTHER RENTAL PROPERTY	07957		194.07
194.08	KELLEY HOME	07958		194.08
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/22/2013 9:42 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	381,153	403,371		1.00
	TOTALS		381,153	403,371		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,488	0		1.00
	TOTALS		1,488	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	30,743		1.00
2.00	RUCHFORD POB	194.03	0	8,449		2.00
3.00	HOSPICE	116.00	0	4,909		3.00
4.00	HOME HEALTH AGENCY	101.00	0	4,909		4.00
	TOTALS		0	49,010		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	58,451		1.00
2.00	RUCHFORD POB	194.03	0	484		2.00
	TOTALS		0	58,935		
	E - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	28,005		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,671,862		2.00
	TOTALS		0	2,699,867		
	F - RHC EXPENSE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	86,263	125,898		1.00
	TOTALS		86,263	125,898		
	G - EXECUTIVE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	113,310		1.00
	TOTALS		0	113,310		
	H - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	10,000		1.00
	TOTALS		0	10,000		
	I - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,265,848		1.00
	TOTALS		0	1,265,848		
	J - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,025,432		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,025,432		
	K - NURSING SCHOOL TUITION FORGIVENESS					
1.00	NURSING SCHOOL	20.00	0	101,561		1.00
	TOTALS		0	101,561		
500.00	Grand Total: Increases		468,904	5,853,232		500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/22/2013 9:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	381,153	403,371	0		1.00
	TOTALS		381,153	403,371			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	1,488	0	0		1.00
	TOTALS		1,488	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	49,010	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	49,010			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,935	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	58,935			
	E - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,699,867	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,699,867			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	86,263	125,898	0		1.00
	TOTALS		86,263	125,898			
	G - EXECUTIVE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,310	0		1.00
	TOTALS		0	113,310			
	H - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0		1.00
	TOTALS		0	10,000			
	I - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,265,848	0		1.00
	TOTALS		0	1,265,848			
	J - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	599,117	0		1.00
2.00	OPERATING ROOM	50.00	0	426,315	0		2.00
	TOTALS		0	1,025,432			
	K - NURSING SCHOOL TUITION FORGIVENESS						
1.00	EMPLOYEE BENEFITS	4.00	0	101,561	0		1.00
	TOTALS		0	101,561			
500.00	Grand Total: Decreases		468,904	5,853,232			500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 11/22/2013 9:42 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	381,153	DIETARY	10.00	381,153	1.00
	TOTALS		381,153	TOTALS		381,153	
	B - MAINTENANCE LABOR RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,488	OPERATION OF PLANT	7.00	1,488	1.00
	TOTALS		1,488	TOTALS		1,488	
	C - OFFSITE CAPITAL RECLASS						
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	RUCHFORD POB	194.03	0		0.00	0	2.00
3.00	HOSPICE	116.00	0		0.00	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0		0.00	0	4.00
	TOTALS		0	TOTALS		0	
	D - PROPERTY INSURANCE RECLASS						
1.00	OTHER CAP REL COSTS	3.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	RUCHFORD POB	194.03	0		0.00	0	2.00
	TOTALS		0	TOTALS		0	
	E - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		0.00	0	2.00
	TOTALS		0	TOTALS		0	
	F - RHC EXPENSE RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	86,263	RURAL HEALTH CLINIC	88.00	86,263	1.00
	TOTALS		86,263	TOTALS		86,263	
	G - EXECUTIVE BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	H - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	I - IMPLANT RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	OPERATING ROOM	50.00	0	1.00
	TOTALS		0	TOTALS		0	
	J - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00		0.00	0	OPERATING ROOM	50.00	0	2.00
	TOTALS		0	TOTALS		0	
	K - NURSING SCHOOL TUITION FORGIVENESS						
1.00	NURSING SCHOOL	20.00	0	EMPLOYEE BENEFITS	4.00	0	1.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		468,904	Grand Total: Decreases		468,904	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,032,683	10,668	0	10,668	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	59,635,987	1,711,552	0	1,711,552	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,652,436	0	0	0	57,068	5.00
6.00	Movable Equipment	27,701,789	464,949	0	464,949	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,022,895	2,187,169	0	2,187,169	57,068	8.00
9.00	Reconciling Items	-1,459,809	0	0	0	-320,316	9.00
10.00	Total (line 8 minus line 9)	107,482,704	2,187,169	0	2,187,169	377,384	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,043,351	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	61,347,539	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	14,595,368	0	5.00
6.00	Movable Equipment	28,166,738	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	108,152,996	0	8.00
9.00	Reconciling Items	-1,139,493	0	9.00
10.00	Total (line 8 minus line 9)	109,292,489	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	6,574,145	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,574,145	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	6,574,145	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	6,574,145	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	79,468,443	0	79,468,443	0.734778	42,948	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	517,815	0	517,815	0.004788	280	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	28,166,738	0	28,166,738	0.260434	15,223	2.00
3.00	Total (sum of lines 1-2)	108,152,996	0	108,152,996	1.000000	58,451	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	42,948	3,825,268	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	280	28,005	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	15,223	2,670,193	0	2.00
3.00	Total (sum of lines 1-2)	0	0	58,451	6,523,466	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-1,117,649	42,948	0	0	2,750,567	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	280	0	0	28,285	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,223	0	0	2,685,416	2.00
3.00	Total (sum of lines 1-2)	-1,117,649	58,451	0	0	5,464,268	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-2,253,008			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-238,161	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	GRI EMPL BENEF OTHER REVENUE	B	-9,527	EMPLOYEE BENEFITS	4.00	0	33.01
33.02	TRADE, QUANTITY AND TIME DISCOUNTS	B	-7,413	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	MEDICAL STAFF DUES	B	-16,100	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	OTHER INCOME & PURCHASE GROUP	B	-109,673	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.07	HOUSKEEPING OTHER REVENUE	B	-2,250	HOUSEKEEPING	9.00	0	33.07
33.08	DIETARY CONSULTANT AND EMP PURCHASE	B	-27,938	DIETARY	10.00	0	33.08
33.09	REFUND/EXP REBATE	B	-1,992	DIETARY	10.00	0	33.09
33.10	CAFETERIA--EMPLOYEES AND GUESTS	B	-413,784	CAFETERIA	11.00	0	33.10
33.12	NRSG SVS CPR CLASS FEES	B	-3,673	NURSING ADMINISTRATION	13.00	0	33.12
33.13	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-274,072	PHARMACY	15.00	0	33.13
33.14	REFUND/EXP REBATE	B	-11,098	PHARMACY	15.00	0	33.14
33.15	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-21,588	MEDICAL RECORDS & LIBRARY	16.00	0	33.15
33.16	LAMAZE CLASS FEES	B	-40	ADULTS & PEDIATRICS	30.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.17
33.19	CT SCAN OTHER REVENUE	B	-2,848	CT SCAN	57.00	0	33.19
33.20	MISCELLANEOUS LAB REVENUE	B	-1,140	LABORATORY	60.00	0	33.20
33.22	CARDIAC OTHER REVENUE	B	-9,163	CARDIAC REHABILITATION	76.97	0	33.22
33.23	RHC OTHER INCOME	B	-131,972	RURAL HEALTH CLINIC	88.00	0	33.23
33.29	HME NON PATIENT SALES	B	-57,905	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.29
33.30	HME HME OTHER REVENUE	B	-19,143	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.30
33.31	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	B	-682,875	NURSING SCHOOL	20.00	0	33.31
33.32	DONATIONS & DUES	A	-10,500	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	CRNA SALARY EXPENSE	A	-1,104,620	ANESTHESIOLOGY	53.00	0	33.33
33.34	CRNA BENEFIT EXPENSE	A	-27,837	EMPLOYEE BENEFITS	4.00	0	33.34
33.35	CRNA CONTRACTED EXPENSE	A	400	ANESTHESIOLOGY	53.00	0	33.35
33.36	UNEMPLOYMENT CASH BASIS	A	-65,647	EMPLOYEE BENEFITS	4.00	0	33.36
33.37	IL PROVIDER PARTICIPATION FEE	A	17,520	SKILLED NURSING FACILITY	44.00	0	33.37
33.38	IL PROVIDER PARTICIPATION FEE	A	9,855	NURSING FACILITY	45.00	0	33.38
33.39	IL HOSPITAL PROVIDER TAX	A	-978,695	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	PHONE SALARIES EXPENSE	A	-4,483	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	PHONE BENEFIT EXPENSE	A	-710	EMPLOYEE BENEFITS	4.00	0	33.41
33.42	PHONE DEPREPATION M/M EXPENSE	A	-675	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.42
33.43	IHA & AHA DUES LOBBYING PORTION	A	-20,785	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	IL HEALTHCARE ASSOCIATION LOBBYING	A	-1,018	SKILLED NURSING FACILITY	44.00	0	33.44
33.45	IL HOMECARE COUNCIL LOBBYING	A	-973	HOME HEALTH AGENCY	101.00	0	33.45
33.47	MARKETING DEPT SALARY EXPENSE	A	-109,754	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	MARKETING DEPT BENEIFT EXPENSE	A	-11,104	EMPLOYEE BENEFITS	4.00	0	33.48
33.50	MARKETING DEPT OTHER EXPENSE	A	-253,175	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	MARKETING DEPRECIATION EXPENSE	A	-994	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.51
33.52	PHYSICIAN RECRUITMENT	A	-2,661	ADMINISTRATIVE & GENERAL	5.00	0	33.52
33.53	LOAN FORGIVENESS EXPENSE	A	-220,840	EMPLOYEE BENEFITS	4.00	0	33.53
33.54	ER PHYSICIAN BENEFITS	A	-32,032	EMPLOYEE BENEFITS	4.00	0	33.54
33.55	SELF INSURANCE COSTS	A	-2,431,547	EMPLOYEE BENEFITS	4.00	0	33.55
33.56	SWAP INTEREST RATE EXPENSE	A	-879,488	CAP REL COSTS-BLDG & FIXT	1.00	11	33.56
33.57			0		0.00	0	33.57
33.58			0		0.00	0	33.58
33.59			0		0.00	0	33.59
33.60			0		0.00	0	33.60
34.00			0		0.00	0	34.00
34.08			0		0.00	0	34.08
37.00			0		0.00	0	37.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,425,146				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2013 9:42 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,017,692	1,997,919	19,773	159,800	86	1.00
2.00	91.00	EMERGENCY	73,500	73,500	0	0	0	2.00
3.00	60.00	LABORATORY	57,000	57,000	0	0	0	3.00
4.00	60.00	LABORATORY	55,890	55,890	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	5,843	5,843	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	49,690	49,690	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			2,259,615	2,239,842	19,773		86	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	6,607	330	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	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			6,607	330	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	6,607	13,166	2,011,085		1.00
2.00	91.00	EMERGENCY	0	0	0	73,500		2.00
3.00	60.00	LABORATORY	0	0	0	57,000		3.00
4.00	60.00	LABORATORY	0	0	0	55,890		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,843		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	49,690		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	6,607	13,166	2,253,008		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NEW CARDIAC REHAB	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,750,567	2,750,567				1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	28,285	0	28,285			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,685,416			2,685,416		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,190,761	17,857	0	2,087	5,210,705	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,966,223	288,306	0	1,236,526	1,142,940	5.00
7.00	00700	OPERATION OF PLANT	2,676,803	322,277	0	13,747	161,484	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	254,980	32,545	0	1,796	5,418	8.00
9.00	00900	HOUSEKEEPING	804,980	31,241	0	9,424	136,658	9.00
10.00	01000	DIETARY	551,120	84,025	0	39,533	57,734	10.00
11.00	01100	CAFETERIA	370,740	22,467	0	0	77,952	11.00
13.00	01300	NURSING ADMINISTRATION	495,494	25,651	0	0	100,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-186,097	0	0	2,130	10,191	14.00
15.00	01500	PHARMACY	424,443	19,210	0	46,187	127,199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	496,913	76,085	0	5,426	88,872	16.00
20.00	02000	NURSING SCHOOL	524,094	250,891	0	27,172	186,713	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,638,245	173,105	0	118,255	508,507	30.00
31.00	03100	INTENSIVE CARE UNIT	560,726	30,196	0	12,414	107,222	31.00
43.00	04300	NURSERY	294,056	8,758	0	4,152	58,706	43.00
44.00	04400	SKILLED NURSING FACILITY	1,091,463	117,275	0	8,700	209,876	44.00
45.00	04500	NURSING FACILITY	637,774	52,832	0	10,092	125,257	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,138,855	141,248	0	301,667	300,792	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,623	25,950	0	45	15,875	52.00
53.00	05300	ANESTHESIOLOGY	74,879	10,216	0	33,857	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,521	88,327	0	157,247	176,285	54.00
57.00	05700	CT SCAN	230,275	0	0	186,926	10,910	57.00
58.00	05800	MRI	172,691	24,046	0	131,720	10,422	58.00
60.00	06000	LABORATORY	3,298,415	119,924	0	74,093	296,566	60.00
65.00	06500	RESPIRATORY THERAPY	499,567	8,912	0	23,112	87,438	65.00
66.00	06600	PHYSICAL THERAPY	1,123,447	35,219	0	4,728	104,706	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,025,432	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,265,848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,824	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	254,501	0	28,285	7,168	46,443	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,177,709	401,019	0	84,908	557,245	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,266,485	105,940	0	93,179	224,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,041,325	0	0	17,629	89,762	96.00
101.00	10100	HOME HEALTH AGENCY	693,882	0	0	17,012	110,344	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	276,776	0	0	6,282	46,099	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,147,041	2,513,522	28,285	2,677,214	5,182,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,771	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	551,396	115,452	0	8,202	28,662	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	22,313	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	37,309	0	0	0	194.02
194.03	07953	RUCHFORD POB	8,933	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	52,200	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	1,955	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	59,709,325	2,750,567	28,285	2,685,416	5,210,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,633,995	12,633,995				5.00
7.00	00700	OPERATION OF PLANT	3,174,311	848,782	4,023,093			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	294,739	78,811	61,699	435,249		8.00
9.00	00900	HOUSEKEEPING	982,303	262,659	59,226	10,776	1,314,964	9.00
10.00	01000	DIETARY	732,412	195,840	159,293	0	51,002	10.00
11.00	01100	CAFETERIA	471,159	125,984	42,592	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	621,540	166,194	48,628	0	9,043	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-173,776	0	0	0	0	14.00
15.00	01500	PHARMACY	617,039	164,991	36,417	0	9,837	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	667,296	178,429	144,240	0	16,231	16.00
20.00	02000	NURSING SCHOOL	988,870	264,415	475,635	303	41,316	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,438,112	919,320	328,169	120,879	324,929	30.00
31.00	03100	INTENSIVE CARE UNIT	710,558	189,997	57,245	11,418	43,246	31.00
43.00	04300	NURSERY	365,672	97,777	16,604	2,994	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,427,314	381,651	222,328	54,254	216,039	44.00
45.00	04500	NURSING FACILITY	825,955	220,853	100,159	58,527	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,882,562	770,771	267,776	85,929	217,893	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,493	31,951	49,196	0	0	52.00
53.00	05300	ANESTHESIOLOGY	118,952	31,807	19,368	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,043,380	546,381	167,448	18,570	43,586	54.00
57.00	05700	CT SCAN	428,111	114,473	0	0	0	57.00
58.00	05800	MRI	338,879	90,613	45,587	5,697	0	58.00
60.00	06000	LABORATORY	3,788,998	1,013,144	227,350	448	29,133	60.00
65.00	06500	RESPIRATORY THERAPY	619,029	165,523	16,895	2,182	7,264	65.00
66.00	06600	PHYSICAL THERAPY	1,268,100	339,079	66,767	10,521	21,680	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,025,432	274,191	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,265,848	338,476	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,824	441,415	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	336,397	89,950	0	0	42,300	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,220,881	3,000,372	760,245	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,689,636	451,793	200,840	50,218	132,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,148,716	307,156	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	821,238	219,592	0	412	7,870	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	329,157	88,014	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,873,132	12,410,404	3,573,707	433,128	1,213,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,771	2,613	18,523	0	7,151	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	703,712	188,166	218,872	1,673	93,831	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	22,313	5,966	42,300	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	37,309	9,976	70,730	448	0	194.02
194.03	07953	RUCHFORD POB	8,933	2,389	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	52,200	13,958	98,961	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	1,955	523	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	59,709,325	12,633,995	4,023,093	435,249	1,314,964	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,138,547					10.00
11.00	01100	CAFETERIA	0	639,735				11.00
13.00	01300	NURSING ADMINISTRATION	0	15,736	861,141			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,292	0	-169,484		14.00
15.00	01500	PHARMACY	0	26,155	0	0	854,439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,631	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	34,119	0	0	88	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	444,386	101,798	657,789	0	525	30.00
31.00	03100	INTENSIVE CARE UNIT	38,179	17,935	115,886	0	65	31.00
43.00	04300	NURSERY	0	10,377	67,048	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	291,534	51,648	0	0	40	44.00
45.00	04500	NURSING FACILITY	364,448	37,556	0	0	55	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,441	0	0	7,251	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,160	20,418	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,547	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,855	0	0	42,143	54.00
57.00	05700	CT SCAN	0	2,092	0	0	1	57.00
58.00	05800	MRI	0	2,050	0	0	0	58.00
60.00	06000	LABORATORY	0	79,724	0	0	254	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,326	0	0	855	65.00
66.00	06600	PHYSICAL THERAPY	0	19,792	0	0	103	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	633,937	73.00
76.97	07697	CARDIAC REHABILITATION	0	9,608	0	0	167	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	152,425	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	54,893	0	0	2,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	3,899	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	62	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	10,043	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,138,547	639,735	861,141	0	853,918	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	521	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	-169,484	0	201.00
202.00		TOTAL (sum lines 118-201)	1,138,547	639,735	861,141	-169,484	854,439	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,046,827					16.00
20.00	02000	NURSING SCHOOL	0	1,804,746				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,294	804,801	7,428,002	0	7,428,002	30.00
31.00	03100	INTENSIVE CARE UNIT	21,789	103,140	1,309,458	0	1,309,458	31.00
43.00	04300	NURSERY	12,413	0	572,885	0	572,885	43.00
44.00	04400	SKILLED NURSING FACILITY	33,465	297,147	2,975,420	0	2,975,420	44.00
45.00	04500	NURSING FACILITY	41,840	7,117	1,656,510	0	1,656,510	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,459	172,296	4,587,378	0	4,587,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	224,218	0	224,218	52.00
53.00	05300	ANESTHESIOLOGY	0	0	180,674	0	180,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,952	41,256	3,187,571	0	3,187,571	54.00
57.00	05700	CT SCAN	0	0	544,677	0	544,677	57.00
58.00	05800	MRI	0	0	482,826	0	482,826	58.00
60.00	06000	LABORATORY	101,191	0	5,240,242	0	5,240,242	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	832,074	0	832,074	65.00
66.00	06600	PHYSICAL THERAPY	0	18,153	1,744,195	0	1,744,195	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,299,623	0	1,299,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,604,324	0	1,604,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,399	2,742,575	0	2,742,575	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,754	503,176	0	503,176	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	103,140	15,237,063	0	15,237,063	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	178,424	22,485	2,782,907	0	2,782,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,459,771	0	1,459,771	96.00
101.00	10100	HOME HEALTH AGENCY	0	76,221	1,125,395	0	1,125,395	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	29,704	456,918	0	456,918	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,046,827	1,716,613	58,177,882	0	58,177,882	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	38,058	0	38,058	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	88,133	1,294,908	0	1,294,908	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	70,579	0	70,579	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	118,463	0	118,463	194.02
194.03	07953	RUCHFORD POB	0	0	11,322	0	11,322	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	165,119	0	165,119	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	2,478	0	2,478	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-169,484	0	-169,484	201.00
202.00		TOTAL (sum lines 118-201)	1,046,827	1,804,746	59,709,325	0	59,709,325	202.00

COST ALLOCATION STATISTICS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	2	SQUARE FEET	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	HOURS OF SERVICE	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTES	11.00
13.00	NURSING ADMINISTRATION	10	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	13	TIME SPENT	16.00
20.00	NURSING SCHOOL	14	ASSIGNED TIME	20.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,857	0	2,087	19,944	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	288,306	0	1,236,526	1,524,832	5.00
7.00	00700	OPERATION OF PLANT	500	322,277	0	13,747	336,524	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,545	0	1,796	34,341	8.00
9.00	00900	HOUSEKEEPING	0	31,241	0	9,424	40,665	9.00
10.00	01000	DIETARY	0	84,025	0	39,533	123,558	10.00
11.00	01100	CAFETERIA	0	22,467	0	0	22,467	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,651	0	0	25,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	523	0	0	2,130	2,653	14.00
15.00	01500	PHARMACY	0	19,210	0	46,187	65,397	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	76,085	0	5,426	81,511	16.00
20.00	02000	NURSING SCHOOL	0	250,891	0	27,172	278,063	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	173,105	0	118,255	291,360	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,196	0	12,414	42,610	31.00
43.00	04300	NURSERY	0	8,758	0	4,152	12,910	43.00
44.00	04400	SKILLED NURSING FACILITY	0	117,275	0	8,700	125,975	44.00
45.00	04500	NURSING FACILITY	0	52,832	0	10,092	62,924	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	141,248	0	301,667	442,915	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,950	0	45	25,995	52.00
53.00	05300	ANESTHESIOLOGY	2,325	10,216	0	33,857	46,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,327	0	157,247	245,574	54.00
57.00	05700	CT SCAN	0	0	0	186,926	186,926	57.00
58.00	05800	MRI	0	24,046	0	131,720	155,766	58.00
60.00	06000	LABORATORY	0	119,924	0	74,093	194,017	60.00
65.00	06500	RESPIRATORY THERAPY	3,267	8,912	0	23,112	35,291	65.00
66.00	06600	PHYSICAL THERAPY	0	35,219	0	4,728	39,947	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	28,285	7,168	35,453	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	401,019	0	84,908	485,927	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	105,940	0	93,179	199,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	30,998	0	0	17,629	48,627	96.00
101.00	10100	HOME HEALTH AGENCY	4,909	0	0	17,012	21,921	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	49,377	0	0	6,282	55,659	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,899	2,513,522	28,285	2,677,214	5,310,920	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,771	0	0	9,771	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115,452	0	8,202	123,654	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	22,313	0	0	22,313	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	37,309	0	0	37,309	194.02
194.03	07953	RUCHFORD POB	8,449	0	0	0	8,449	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	52,200	0	0	52,200	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	100,348	2,750,567	28,285	2,685,416	5,564,616	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,944					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,369	1,529,201				5.00
7.00	00700	OPERATION OF PLANT	618	102,737	439,879			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21	9,539	6,746	50,647		8.00
9.00	00900	HOUSEKEEPING	523	31,792	6,476	1,254	80,710	9.00
10.00	01000	DIETARY	221	23,705	17,417	0	3,130	10.00
11.00	01100	CAFETERIA	298	15,249	4,657	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	384	20,116	5,317	0	555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39	0	0	0	0	14.00
15.00	01500	PHARMACY	487	19,970	3,982	0	604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	340	21,597	15,771	0	996	16.00
20.00	02000	NURSING SCHOOL	715	32,005	52,005	35	2,536	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,947	111,274	35,882	14,067	19,944	30.00
31.00	03100	INTENSIVE CARE UNIT	411	22,997	6,259	1,329	2,654	31.00
43.00	04300	NURSERY	225	11,835	1,815	348	0	43.00
44.00	04400	SKILLED NURSING FACILITY	804	46,195	24,309	6,313	13,260	44.00
45.00	04500	NURSING FACILITY	480	26,732	10,951	6,810	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,152	93,294	29,278	9,999	13,374	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61	3,867	5,379	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,850	2,118	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675	66,134	18,309	2,161	2,675	54.00
57.00	05700	CT SCAN	42	13,856	0	0	0	57.00
58.00	05800	MRI	40	10,968	4,984	663	0	58.00
60.00	06000	LABORATORY	1,135	122,631	24,858	52	1,788	60.00
65.00	06500	RESPIRATORY THERAPY	335	20,035	1,847	254	446	65.00
66.00	06600	PHYSICAL THERAPY	401	41,042	7,300	1,224	1,331	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,188	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,969	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	53,429	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	178	10,887	0	0	2,596	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,133	363,150	83,124	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	858	54,685	21,960	5,843	8,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	344	37,178	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	422	26,579	0	48	483	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	176	10,653	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,834	1,502,138	390,744	50,400	74,512	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	316	2,025	0	439	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	110	22,776	23,931	195	5,759	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	722	4,625	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	1,208	7,734	52	0	194.02
194.03	07953	RUCHFORD POB	0	289	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	1,689	10,820	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	63	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
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)	19,944	1,529,201	439,879	50,647	80,710	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	168,031					10.00
11.00	01100	CAFETERIA	0	42,671				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,050	53,073			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	286	0	2,978		14.00
15.00	01500	PHARMACY	0	1,745	0	0	92,185	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,710	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	2,276	0	0	9	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,583	6,788	40,541	0	57	30.00
31.00	03100	INTENSIVE CARE UNIT	5,635	1,196	7,142	0	7	31.00
43.00	04300	NURSERY	0	692	4,132	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	43,026	3,445	0	0	4	44.00
45.00	04500	NURSING FACILITY	53,787	2,505	0	0	6	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,965	0	0	782	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	211	1,258	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	704	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,525	0	0	4,547	54.00
57.00	05700	CT SCAN	0	140	0	0	0	57.00
58.00	05800	MRI	0	137	0	0	0	58.00
60.00	06000	LABORATORY	0	5,318	0	0	27	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,356	0	0	92	65.00
66.00	06600	PHYSICAL THERAPY	0	1,320	0	0	11	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	68,396	73.00
76.97	07697	CARDIAC REHABILITATION	0	641	0	0	18	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	16,445	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,661	0	0	216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	421	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	7	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,084	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,031	42,671	53,073	0	92,129	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	56	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	2,978	0	201.00
202.00		TOTAL (sum lines 118-201)	168,031	42,671	53,073	2,978	92,185	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,925					16.00
20.00	02000	NURSING SCHOOL	0	367,644				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,735		621,178	0	621,178	30.00
31.00	03100	INTENSIVE CARE UNIT	2,559		92,799	0	92,799	31.00
43.00	04300	NURSERY	1,458		33,415	0	33,415	43.00
44.00	04400	SKILLED NURSING FACILITY	3,930		267,261	0	267,261	44.00
45.00	04500	NURSING FACILITY	4,913		169,108	0	169,108	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,497		609,256	0	609,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		36,771	0	36,771	52.00
53.00	05300	ANESTHESIOLOGY	0		53,070	0	53,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,999		371,599	0	371,599	54.00
57.00	05700	CT SCAN	0		200,964	0	200,964	57.00
58.00	05800	MRI	0		172,558	0	172,558	58.00
60.00	06000	LABORATORY	11,882		361,708	0	361,708	60.00
65.00	06500	RESPIRATORY THERAPY	0		59,656	0	59,656	65.00
66.00	06600	PHYSICAL THERAPY	0		92,576	0	92,576	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		33,188	0	33,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		40,969	0	40,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		121,825	0	121,825	73.00
76.97	07697	CARDIAC REHABILITATION	0		49,773	0	49,773	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		950,779	0	950,779	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	20,952		315,434	0	315,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		86,570	0	86,570	96.00
101.00	10100	HOME HEALTH AGENCY	0		49,460	0	49,460	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		67,572	0	67,572	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	122,925	0	4,857,489	0	4,857,489	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		12,551	0	12,551	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		176,481	0	176,481	192.00
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
193.01	19301	NONPAID WORKERS	0		0	0	0	193.01
193.02	19302	FOUNDATION	0		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0		27,660	0	27,660	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0		46,303	0	46,303	194.02
194.03	07953	RUCHFORD POB	0		8,738	0	8,738	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		64,709	0	64,709	194.04
194.05	07955	FARMINGTON POB	0		0	0	0	194.05
194.06	07956	LEWISTON POB	0		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0		63	0	63	194.07
194.08	07958	KELLEY HOME	0		0	0	0	194.08
200.00		Cross Foot Adjustments		367,644	367,644	0	367,644	200.00
201.00		Negative Cost Centers	0	0	2,978	0	2,978	201.00
202.00		TOTAL (sum lines 118-201)	122,925	367,644	5,564,616	0	5,564,616	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	339,497					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,671,861			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,204	0	2,076	25,478,366		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,585	0	1,230,286	5,588,553	-12,633,995	5.00
7.00	00700	OPERATION OF PLANT	39,778	0	13,678	789,595	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,017	0	1,787	26,493	0	8.00
9.00	00900	HOUSEKEEPING	3,856	0	9,376	668,204	0	9.00
10.00	01000	DIETARY	10,371	0	39,333	282,297	0	10.00
11.00	01100	CAFETERIA	2,773	0	0	381,153	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,166	0	0	490,891	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,119	49,830	173,776	14.00
15.00	01500	PHARMACY	2,371	0	45,954	621,954	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,391	0	5,399	434,552	0	16.00
20.00	02000	NURSING SCHOOL	30,967	0	27,035	912,954	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,366	0	117,658	2,486,405	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,727	0	12,351	524,275	0	31.00
43.00	04300	NURSERY	1,081	0	4,131	287,052	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,475	0	8,656	1,026,211	0	44.00
45.00	04500	NURSING FACILITY	6,521	0	10,041	612,457	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,434	0	300,144	1,470,756	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,203	0	45	77,623	0	52.00
53.00	05300	ANESTHESIOLOGY	1,261	0	33,686	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,902	0	156,453	861,967	0	54.00
57.00	05700	CT SCAN	0	0	185,983	53,348	0	57.00
58.00	05800	MRI	2,968	0	131,055	50,960	0	58.00
60.00	06000	LABORATORY	14,802	0	73,719	1,450,094	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,100	0	22,995	427,538	0	65.00
66.00	06600	PHYSICAL THERAPY	4,347	0	4,704	511,974	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	30,653	7,132	227,089	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	49,497	0	84,479	2,724,713	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,076	0	92,709	1,095,433	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	17,540	438,902	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	16,926	539,541	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	6,250	225,406	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,239	30,653	2,663,700	25,338,220	-12,460,219	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,206	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,250	0	8,161	140,146	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,754	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	4,605	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,443	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
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)	2,750,567	28,285	2,685,416	5,210,705		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.101889	0.922748	1.005073	0.204515		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	CAPITAL RELATED COSTS				Reconciliation	
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)		
			1.00	1.01	2.00	4.00	5A	
204.00		Cost to be allocated (per Wkst. B, Part II)				19,944		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000783		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,249,106					5.00
7.00	00700	OPERATION OF PLANT	3,174,311	261,930				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	294,739	4,017	933,613			8.00
9.00	00900	HOUSEKEEPING	982,303	3,856	23,114	34,755		9.00
10.00	01000	DIETARY	732,412	10,371	0	1,348	57,854	10.00
11.00	01100	CAFETERIA	471,159	2,773	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	621,540	3,166	0	239	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	617,039	2,371	0	260	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	667,296	9,391	0	429	0	16.00
20.00	02000	NURSING SCHOOL	988,870	30,967	650	1,092	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,438,112	21,366	259,285	8,588	22,581	30.00
31.00	03100	INTENSIVE CARE UNIT	710,558	3,727	24,492	1,143	1,940	31.00
43.00	04300	NURSERY	365,672	1,081	6,422	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,427,314	14,475	116,376	5,710	14,814	44.00
45.00	04500	NURSING FACILITY	825,955	6,521	125,541	0	18,519	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,882,562	17,434	184,319	5,759	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,493	3,203	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	118,952	1,261	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,043,380	10,902	39,832	1,152	0	54.00
57.00	05700	CT SCAN	428,111	0	0	0	0	57.00
58.00	05800	MRI	338,879	2,968	12,220	0	0	58.00
60.00	06000	LABORATORY	3,788,998	14,802	962	770	0	60.00
65.00	06500	RESPIRATORY THERAPY	619,029	1,100	4,680	192	0	65.00
66.00	06600	PHYSICAL THERAPY	1,268,100	4,347	22,568	573	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,025,432	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,265,848	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650,824	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	336,397	0	0	1,118	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,220,881	49,497	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,689,636	13,076	107,718	3,505	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,148,716	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	821,238	0	884	208	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	329,157	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,412,913	232,672	929,063	32,086	57,854	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,771	1,206	0	189	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	703,712	14,250	3,588	2,480	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	22,313	2,754	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	37,309	4,605	962	0	0	194.02
194.03	07953	RUCHFORD POB	8,933	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	52,200	6,443	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	1,955	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
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)	12,633,995	4,023,093	435,249	1,314,964	1,138,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.267391	15.359420	0.466199	37.835247	19.679659	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,529,201	439,879	50,647	80,710	168,031	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.032365	1.679376	0.054248	2.322256	2.904397	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	29,963					11.00
13.00	01300	NURSING ADMINISTRATION	737	6,242				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	201	0	2,967,049			14.00
15.00	01500	PHARMACY	1,225	0	37,510	2,158,577		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,903	0	0	0	126,500	16.00
20.00	02000	NURSING SCHOOL	1,598	0	3,626	222	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,768	4,768	35,093	1,327	34,717	30.00
31.00	03100	INTENSIVE CARE UNIT	840	840	8,338	163	2,633	31.00
43.00	04300	NURSERY	486	486	4,716	0	1,500	43.00
44.00	04400	SKILLED NURSING FACILITY	2,419	0	11,333	101	4,044	44.00
45.00	04500	NURSING FACILITY	1,759	0	4,553	138	5,056	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,784	0	290,356	18,319	14,919	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	148	148	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	494	0	5,528	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,773	0	10,048	106,466	29,842	54.00
57.00	05700	CT SCAN	98	0	6,885	3	0	57.00
58.00	05800	MRI	96	0	128	0	0	58.00
60.00	06000	LABORATORY	3,734	0	26,769	642	12,228	60.00
65.00	06500	RESPIRATORY THERAPY	952	0	14,813	2,159	0	65.00
66.00	06600	PHYSICAL THERAPY	927	0	5,793	259	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,027,166	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,265,848	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,601,524	0	73.00
76.97	07697	CARDIAC REHABILITATION	450	0	744	422	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	152,766	385,072	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,571	0	32,588	5,064	21,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	9,850	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	21,818	157	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	25,373	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,963	6,242	2,966,419	2,157,261	126,500	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	630	1,316	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
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)	639,735	861,141	-169,484	854,439	1,046,827	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.350833	137.959148	0.000000	0.395834	8.275312	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,671	53,073	2,978	92,185	122,925	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1.424123	8.502563	0.001004	0.042706	0.971739	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	
			20.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
20.00	02000	NURSING SCHOOL	874,900	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	390,150	30.00
31.00	03100	INTENSIVE CARE UNIT	50,000	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	144,050	44.00
45.00	04500	NURSING FACILITY	3,450	45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	83,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,000	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	8,800	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,950	73.00
76.97	07697	CARDIAC REHABILITATION	12,000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	50,000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	10,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	96.00
101.00	10100	HOME HEALTH AGENCY	36,950	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	14,400	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	832,175	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,725	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	NONPAID WORKERS	0	193.01
193.02	19302	FOUNDATION	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	194.02
194.03	07953	RUCHFORD POB	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	194.04
194.05	07955	FARMINGTON POB	0	194.05
194.06	07956	LEWISTON POB	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	194.07
194.08	07958	KELLEY HOME	0	194.08
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)	1,804,746	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.062803	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	367,644	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/22/2013 9:42 am

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
			20.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.420213		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/22/2013 9:42 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,428,002		7,428,002	0	7,428,002	30.00
31.00	03100	INTENSIVE CARE UNIT	1,309,458		1,309,458	0	1,309,458	31.00
43.00	04300	NURSERY	572,885		572,885	0	572,885	43.00
44.00	04400	SKILLED NURSING FACILITY	2,975,420		2,975,420	0	2,975,420	44.00
45.00	04500	NURSING FACILITY	1,656,510		1,656,510	0	1,656,510	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,587,378		4,587,378	0	4,587,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224,218		224,218	0	224,218	52.00
53.00	05300	ANESTHESIOLOGY	180,674		180,674	0	180,674	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,187,571		3,187,571	0	3,187,571	54.00
57.00	05700	CT SCAN	544,677		544,677	0	544,677	57.00
58.00	05800	MRI	482,826		482,826	0	482,826	58.00
60.00	06000	LABORATORY	5,240,242		5,240,242	0	5,240,242	60.00
65.00	06500	RESPIRATORY THERAPY	832,074	0	832,074	0	832,074	65.00
66.00	06600	PHYSICAL THERAPY	1,744,195	0	1,744,195	0	1,744,195	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,299,623		1,299,623	0	1,299,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,604,324		1,604,324	0	1,604,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,742,575		2,742,575	0	2,742,575	73.00
76.97	07697	CARDIAC REHABILITATION	503,176		503,176	0	503,176	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,237,063		15,237,063	0	15,237,063	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,782,907		2,782,907	13,166	2,796,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	980,078		980,078		980,078	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,459,771		1,459,771	0	1,459,771	96.00
101.00	10100	HOME HEALTH AGENCY	1,125,395		1,125,395		1,125,395	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	456,918		456,918		456,918	116.00
200.00		Subtotal (see instructions)	59,157,960	0	59,157,960	13,166	59,171,126	200.00
201.00		Less Observation Beds	980,078		980,078		980,078	201.00
202.00		Total (see instructions)	58,177,882	0	58,177,882	13,166	58,191,048	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/22/2013 9:42 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,400,792		7,400,792			30.00
31.00	03100	INTENSIVE CARE UNIT	1,623,156		1,623,156			31.00
43.00	04300	NURSERY	268,141		268,141			43.00
44.00	04400	SKILLED NURSING FACILITY	1,930,154		1,930,154			44.00
45.00	04500	NURSING FACILITY	1,101,668		1,101,668			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,803,443	10,631,523	16,434,966	0.279123	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	625,779	134,932	760,711	0.294748	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	802,474	1,216,498	2,018,972	0.089488	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,635,974	16,070,322	17,706,296	0.180025	0.000000	54.00
57.00	05700	CT SCAN	1,205,515	7,942,151	9,147,666	0.059543	0.000000	57.00
58.00	05800	MRI	271,731	4,686,045	4,957,776	0.097388	0.000000	58.00
60.00	06000	LABORATORY	4,724,091	18,931,734	23,655,825	0.221520	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,929,505	1,519,214	5,448,719	0.152710	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,726,310	2,002,644	3,728,954	0.467744	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,822,307	1,801,368	4,623,675	0.281080	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,950,919	655,891	3,606,810	0.444804	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,526,245	2,744,776	8,271,021	0.331588	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	1,327	400,748	402,075	1.251448	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,436,747	19,436,747			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,367,184	12,477,006	15,844,190	0.175642	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	280,388	645,083	925,471	1.059005	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,758,518	2,758,518	0.529187	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	1,093,197	1,093,197			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	507,440	507,440			116.00
200.00		Subtotal (see instructions)	47,997,103	105,655,837	153,652,940			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,997,103	105,655,837	153,652,940			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/22/2013 9:42 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.279123	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294748	52.00
53.00	05300	ANESTHESIOLOGY	0.089488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180025	54.00
57.00	05700	CT SCAN	0.059543	57.00
58.00	05800	MRI	0.097388	58.00
60.00	06000	LABORATORY	0.221520	60.00
65.00	06500	RESPIRATORY THERAPY	0.152710	65.00
66.00	06600	PHYSICAL THERAPY	0.467744	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.444804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331588	73.00
76.97	07697	CARDIAC REHABILITATION	1.251448	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.176473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.059005	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.529187	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part I Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	621,178	0	621,178	7,435	83.55	30.00
31.00	INTENSIVE CARE UNIT	92,799		92,799	828	112.08	31.00
43.00	NURSERY	33,415		33,415	573	58.32	43.00
44.00	SKILLED NURSING FACILITY	267,261		267,261	4,854	55.06	44.00
45.00	NURSING FACILITY	169,108		169,108	6,173	27.39	45.00
200.00	Total (lines 30-199)	1,183,761		1,183,761	19,863		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,153	263,433				30.00
31.00	INTENSIVE CARE UNIT	350	39,228				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,354	184,671				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	6,857	487,332				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	609,256	16,434,966	0.037071	2,088,678	77,429	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,771	760,711	0.048338	832	40	52.00
53.00	05300	ANESTHESIOLOGY	53,070	2,018,972	0.026286	278,346	7,317	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	371,599	17,706,296	0.020987	910,772	19,114	54.00
57.00	05700	CT SCAN	200,964	9,147,666	0.021969	608,487	13,368	57.00
58.00	05800	MRI	172,558	4,957,776	0.034806	149,953	5,219	58.00
60.00	06000	LABORATORY	361,708	23,655,825	0.015290	2,788,231	42,632	60.00
65.00	06500	RESPIRATORY THERAPY	59,656	5,448,719	0.010949	570,131	6,242	65.00
66.00	06600	PHYSICAL THERAPY	92,576	3,728,954	0.024826	228,447	5,671	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	33,188	4,623,675	0.007178	2,072,717	14,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,969	3,606,810	0.011359	1,427,373	16,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,825	8,271,021	0.014729	2,027,018	29,856	73.00
76.97	07697	CARDIAC REHABILITATION	49,773	402,075	0.123790	509	63	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	950,779	19,436,747	0.048917	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	315,434	15,844,190	0.019908	1,563,391	31,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,961	925,471	0.088561	141,810	12,559	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	86,570	2,758,518	0.031383	0	0	96.00
200.00		Total (lines 50-199)	3,638,657	139,728,392		14,856,695	281,726	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part III Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	804,801	0	0	0	804,801	30.00
31.00	03100	INTENSIVE CARE UNIT	103,140	0	0		103,140	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	297,147	0	0		297,147	44.00
45.00	04500	NURSING FACILITY	7,117	0	0		7,117	45.00
200.00		Total (lines 30-199)	1,212,205	0	0		1,212,205	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,435	108.24	3,153	341,281	0	30.00
31.00	03100	INTENSIVE CARE UNIT	828	124.57	350	43,600	0	31.00
43.00	04300	NURSERY	573	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,854	61.22	3,354	205,332	0	44.00
45.00	04500	NURSING FACILITY	6,173	1.15	0	0	0	45.00
200.00		Total (lines 30-199)	19,863		6,857	590,213	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	172,296	0	0	172,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,256	0	0	41,256	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,153	0	0	18,153	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,399	0	0	16,399	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,754	0	0	24,754	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	103,140	0	0	103,140	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	22,485	0	0	22,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	106,189	0	0	106,189	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	504,672	0	0	504,672	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,296	16,434,966	0.010484	0.010484	2,088,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	760,711	0.000000	0.000000	832	52.00
53.00	05300	ANESTHESIOLOGY	0	2,018,972	0.000000	0.000000	278,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,256	17,706,296	0.002330	0.002330	910,772	54.00
57.00	05700	CT SCAN	0	9,147,666	0.000000	0.000000	608,487	57.00
58.00	05800	MRI	0	4,957,776	0.000000	0.000000	149,953	58.00
60.00	06000	LABORATORY	0	23,655,825	0.000000	0.000000	2,788,231	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,448,719	0.000000	0.000000	570,131	65.00
66.00	06600	PHYSICAL THERAPY	18,153	3,728,954	0.004868	0.004868	228,447	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,623,675	0.000000	0.000000	2,072,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,606,810	0.000000	0.000000	1,427,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,399	8,271,021	0.001983	0.001983	2,027,018	73.00
76.97	07697	CARDIAC REHABILITATION	24,754	402,075	0.061566	0.061566	509	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,140	19,436,747	0.005306	0.005306	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	22,485	15,844,190	0.001419	0.001419	1,563,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	106,189	925,471	0.114740	0.114740	141,810	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,758,518	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	504,672	139,728,392			14,856,695	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,898	0	2,954,707	0	30,977	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	348,478	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,122	0	4,858,740	0	11,321	54.00
57.00	05700	CT SCAN	0	0	2,659,219	0	0	57.00
58.00	05800	MRI	0	0	1,261,041	0	0	58.00
60.00	06000	LABORATORY	0	0	1,565,158	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	170,030	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,112	0	7,729	0	38	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	644,844	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	188,616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,020	0	778,856	0	1,544	73.00
76.97	07697	CARDIAC REHABILITATION	31	0	182,012	0	11,206	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,218	0	2,988,084	0	4,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,271	0	343,399	0	39,402	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	47,672	0	18,950,913	0	98,728	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			21.00	22.00	23.00	24.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
200.00		Total (lines 50-199)	0	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.) before 1/1	Charges: PPS Reimbursed Services (see inst.) on/after 1/1	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	4.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.279123	0	2,954,707	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.089488	0	348,478	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180025	0	4,858,740	0	0	54.00
57.00	05700	CT SCAN	0.059543	0	2,659,219	0	0	57.00
58.00	05800	MRI	0.097388	0	1,261,041	0	0	58.00
60.00	06000	LABORATORY	0.221520	0	1,565,158	3,475	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.152710	0	170,030	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.467744	0	7,729	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281080	0	644,844	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.444804	0	188,616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331588	0	778,856	0	7,510	73.00
76.97	07697	CARDIAC REHABILITATION	1.251448	0	182,012	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.175642	0	2,988,084	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.059005	0	343,399	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.529187	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	18,950,913	3,475	7,510	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	18,950,913	3,475	7,510	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs					
			PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	824,727	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	31,185	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	874,695	0	0		54.00
57.00	05700	CT SCAN	0	158,338	0	0		57.00
58.00	05800	MRI	0	122,810	0	0		58.00
60.00	06000	LABORATORY	0	346,714	770	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	25,965	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,615	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	181,253	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	83,897	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	258,259	0	2,490		73.00
76.97	07697	CARDIAC REHABILITATION	0	227,779	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	524,833	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	363,661	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
200.00		Subtotal (see instructions)	0	4,027,731	770	2,490		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,027,731	770	2,490		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	172,296	0	0	172,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,256	0	0	41,256	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,153	0	0	18,153	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,399	0	0	16,399	73.00
76.97	07697	CARDIAC REHABILITATION	0	24,754	0	0	24,754	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	103,140	0	0	103,140	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	22,485	0	0	22,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	398,483	0	0	398,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	172,296	16,434,966	0.010484	0.010484	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	760,711	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,018,972	0.000000	0.000000	525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,256	17,706,296	0.002330	0.002330	11,914	54.00
57.00	05700	CT SCAN	0	9,147,666	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	4,957,776	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	23,655,825	0.000000	0.000000	37,549	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,448,719	0.000000	0.000000	109,721	65.00
66.00	06600	PHYSICAL THERAPY	18,153	3,728,954	0.004868	0.004868	949,201	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,623,675	0.000000	0.000000	738,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,606,810	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,399	8,271,021	0.001983	0.001983	386,771	73.00
76.97	07697	CARDIAC REHABILITATION	24,754	402,075	0.061566	0.061566	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,140	19,436,747	0.005306	0.005306	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	22,485	15,844,190	0.001419	0.001419	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	925,471	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,758,518	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	398,483	139,728,392			2,234,015	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,621	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	767	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	5,416	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			21.00	22.00	23.00	24.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
200.00		Total (lines 50-199)	0	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.) before 1/1	Charges: PPS Reimbursed Services (see inst.) on/after 1/1	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			1.00	2.00	2.01	3.00	4.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.279123	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294748	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.089488	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180025	0	0	0	0	54.00
57.00	05700	CT SCAN	0.059543	0	0	0	0	57.00
58.00	05800	MRI	0.097388	0	0	0	0	58.00
60.00	06000	LABORATORY	0.221520	0	0	18	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.152710	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.467744	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281080	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.444804	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331588	0	0	339	1,422	73.00
76.97	07697	CARDIAC REHABILITATION	1.251448	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.175642	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.059005	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.529187	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	357	1,422	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	357	1,422	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	0	4	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112	472		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
200.00		Subtotal (see instructions)	0	0	116	472		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	116	472		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,435	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,435	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)	6,454	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,153	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,428,002	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,428,002	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,428,002	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)	999.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,150,036	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)	3,150,036	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,309,458	828	1,581.47	350	553,515	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)	3,950,863	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,654,414	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)	687,542	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	329,398	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,016,940	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,637,474	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)	981	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	999.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	980,078	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/22/2013 9:42 am

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	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	621,178	7,428,002	0.083627	980,078	81,961	90.00
91.00	Nursing School cost	804,801	7,428,002	0.108347	980,078	106,189	91.00
92.00	Allied health cost	0	7,428,002	0.000000	980,078	0	92.00
93.00	All other Medical Education	0	7,428,002	0.000000	980,078	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,854	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,854	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)	4,854	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,354	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,975,420	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,975,420	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,975,420	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,975,420	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	612.98	71.00
72.00	Program routine service cost (line 9 x line 71)	2,055,935	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,055,935	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,055,935	83.00
84.00	Program inpatient ancillary services (see instructions)	807,028	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,862,963	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/22/2013 9:42 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,258,220		30.00
31.00	03100	INTENSIVE CARE UNIT		755,328		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279123	2,088,678	582,998	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294748	832	245	52.00
53.00	05300	ANESTHESIOLOGY	0.089488	278,346	24,909	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180025	910,772	163,962	54.00
57.00	05700	CT SCAN	0.059543	608,487	36,231	57.00
58.00	05800	MRI	0.097388	149,953	14,604	58.00
60.00	06000	LABORATORY	0.221520	2,788,231	617,649	60.00
65.00	06500	RESPIRATORY THERAPY	0.152710	570,131	87,065	65.00
66.00	06600	PHYSICAL THERAPY	0.467744	228,447	106,855	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281080	2,072,717	582,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.444804	1,427,373	634,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331588	2,027,018	672,135	73.00
76.97	07697	CARDIAC REHABILITATION	1.251448	509	637	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.176473	1,563,391	275,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.059005	141,810	150,177	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.529187	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		14,856,695	3,950,863	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)		14,856,695		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279123	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294748	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.089488	525	47	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180025	11,914	2,145	54.00
57.00	05700	CT SCAN	0.059543	0	0	57.00
58.00	05800	MRI	0.097388	0	0	58.00
60.00	06000	LABORATORY	0.221520	37,549	8,318	60.00
65.00	06500	RESPIRATORY THERAPY	0.152710	109,721	16,755	65.00
66.00	06600	PHYSICAL THERAPY	0.467744	949,201	443,983	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281080	738,334	207,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.444804	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331588	386,771	128,249	73.00
76.97	07697	CARDIAC REHABILITATION	1.251448	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.175642	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.059005	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.529187	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		2,234,015	807,028	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)		2,234,015		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1	
		0	1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		4,905,463		1.00
2.00	Outlier payments for discharges. (see instructions)		70,342		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		43.24		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.61		30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.11		31.00
32.00	Sum of lines 30 and 31		22.72		32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.96		33.00
34.00	Disproportionate share adjustment (see instructions)		390,475		34.00
	Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Date/Time Prepared: 11/22/2013 9:42 am

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			before 1/1	on/after 1/1	
		0	1.00	1.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		5,366,280		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,878,620		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		5,878,620		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		398,905		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		384,881		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		47,672		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,710,078		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,710,078		61.00
62.00	Deductibles billed to program beneficiaries		775,240		62.00
63.00	Coinsurance billed to program beneficiaries		3,242		63.00
64.00	Allowable bad debts (see instructions)		154,189		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		107,932		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		112,668		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,039,528		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00			0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		8,348		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-26,587		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2012	101,169		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	163,942		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,286,400		71.00
71.01	Sequestration adjustment (see instructions)		31,432		71.01
72.00	Interim payments		6,829,943		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-574,975		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		347,993		75.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 9:42 am
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			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.61	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.11	0.00			20.11	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.72	0.00			20.11	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	SCH				SCH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	43.24	0.00			43.24	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	7.96	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,502	0			1,502	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	110	0			110	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,612	0			1,612	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,855	0			7,855	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	160	0			160	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	8,015	0			8,015	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.11	0.00			20.11	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/22/2013 9:42 am

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	7.96		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		7.96		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		7.96		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/22/2013 9:42 am

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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.82		29.00
30.00	Line 28 or 29 as applicable	5.82		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2013 9:42 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	4,905,463	0	1,226,366	3,679,097	1.00
2.00	Outlier payments for discharges (see instructions)	2.00	70,342	0	17,586	52,756	2.00
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0796	0.0796	0.0796	0.0796	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	390,475	0	97,619	292,856	11.00
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,366,280	0	1,341,571	4,024,709	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	5,878,620	0	1,469,655	4,408,965	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	5,878,620	0	1,469,655	4,408,965	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	398,905	0	99,727	299,178	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,569,382	4,708,143	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	387,338	0	96,835	290,503	20.00
21.00	Capital DRG outlier payments	2.00	11,567	0	2,892	8,675	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	398,905	0	99,727	299,178	26.00
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.064464	0.034821	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			101,169		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				163,942	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/22/2013 9:42 am

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		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	4,905,463		1.00
2.00	Outlier payments for discharges (see instructions)	70,342		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	390,475		11.00
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	5,366,280		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	5,878,620		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	5,878,620		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	398,905		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	6,277,525		19.00
		5.00		
20.00	Capital DRG other than outlier	387,338		20.00
21.00	Capital DRG outlier payments	11,567		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	398,905		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	101,169		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	163,942		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part B Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	3,260		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	3,929,003	2.00
3.00	PPS payments	0	3,425,062	3.00
4.00	Outlier payment (see instructions)	0	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	0.862	5.00
6.00	Line 2 times line 5	0	3,386,801	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	98,728		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,260		11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12.00	Ancillary service charges	10,985		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)	10,985		14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0		16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000		17.00
18.00	Total customary charges (see instructions)	10,985		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,725		19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0		20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,260		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)	3,523,790		24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance (for CAH, see instructions)	0		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	840,659		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)	2,686,391		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)	2,686,391		30.00
31.00	Primary payer payments	0		31.00
32.00	Subtotal (line 30 minus line 31)	2,686,391		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)	142,124		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	99,487		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	117,794		36.00
37.00	Subtotal (see instructions)	2,785,878		37.00
38.00	MSP-LCC reconciliation amount from PS&R	0		38.00
39.00		0		39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	2,785,878		40.00
40.01	Sequestration adjustment (see instructions)	13,929		40.01
41.00	Interim payments	2,773,199		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	-1,250		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	1,652		44.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00
92.00	The rate used to calculate the Time Value of Money	0.00		92.00
93.00	Time Value of Money (see instructions)	0		93.00
94.00	Total (sum of lines 91 and 93)	0		94.00
			Overrides	
			1.00	
	WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Skilled Nursing Facility	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	588		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	588		11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12.00	Ancillary service charges	1,779		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)	1,779		14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0		16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000		17.00
18.00	Total customary charges (see instructions)	1,779		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,191		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)	588		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)	18		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)	570		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)	570		30.00
31.00	Primary payer payments	0		31.00
32.00	Subtotal (line 30 minus line 31)	570		32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	0		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		36.00
37.00	Subtotal (see instructions)	570		37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	570		40.00
40.01	Sequestration adjustment (see instructions)	3		40.01
41.00	Interim payments	433		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	134		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		44.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Skilled Nursing Facility	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2013 9:42 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,807,177		2,768,305	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	01/17/2013	4,894	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	01/17/2013	188,105		0	3.50
3.51		05/16/2013	789,129		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)		-977,234		4,894	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)		6,829,943		2,773,199	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		12,679	6.01
6.02	SETTLEMENT TO PROGRAM		543,543		0	6.02
7.00	Total Medicare program liability (see instructions)		6,286,400		2,785,878	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part I Date/Time Prepared: 11/22/2013 9:42 am
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,024,050		433	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)		1,024,050		433	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		216,824		137	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,240,874		570	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,177,238	1.00
2.00	Routine service other pass through costs	205,332	2.00
3.00	Ancillary service other pass through costs	5,416	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,387,986	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	147,112	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,240,874	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00		0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,240,874	15.00
15.01	Sequestration adjustment (see instructions)	6,204	15.01
16.00	Interim payments	1,024,050	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	210,620	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	3,433	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 11/22/2013 9:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,977,207	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	9,508,853	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	1,429,932	0	0	0	7.00
8.00	Prepaid expenses	1,477,429	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,393,421	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,043,351	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	61,347,539	0	0	0	15.00
16.00	Accumulated depreciation	-56,039,075	0	0	0	16.00
17.00	Leasehold improvements	1,139,493	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	28,166,738	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	14,595,368	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)	53,253,414	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	55,131,608	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	10,645,273	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	65,776,881	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	137,423,716	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,084,976	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,273,627	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	775,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,835,766	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,969,369	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,570,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,687,354	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	36,257,354	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	46,226,723	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	91,196,993				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)	91,196,993	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	137,423,716	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 11/22/2013 9:42 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		83,053,241		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,143,755				2.00
3.00	Total (sum of line 1 and line 2)		91,196,996		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		91,196,996		0		11.00
12.00	ROUNDING	3		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		91,196,993		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	ROUNDING		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: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2013 9:42 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,485,802		8,485,802	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,935,926		1,935,926	7.00
8.00	NURSING FACILITY	1,101,668		1,101,668	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,523,396		11,523,396	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,848,176		1,848,176	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,848,176		1,848,176	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,371,572		13,371,572	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	1	1	2	19.00
20.00	RURAL HEALTH CLINIC	0	19,436,747	19,436,747	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,093,197	1,093,197	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	1	507,439	507,440	26.00
27.00	DME	0	2,758,518	2,758,518	27.00
27.01	OPERATING ROOM	10,026,339	12,602,551	22,628,890	27.01
27.02	DELIVERY ROOM & LABOR ROOM	632,644	136,642	769,286	27.02
27.03	ANESTHESIOLOGY	2,166,852	3,357,823	5,524,675	27.03
27.04	RADIOLOGY-DIAGNOSTIC	1,674,916	16,418,478	18,093,394	27.04
27.05	CT SCAN	1,206,097	8,134,346	9,340,443	27.05
27.06	MRI	271,731	4,871,503	5,143,234	27.06
27.07	LABORATORY	4,855,058	19,061,536	23,916,594	27.07
27.08	RESPIRATORY THERAPY	3,945,539	530,920	4,476,459	27.08
27.09	PHYSICAL THERAPY	1,736,845	2,098,057	3,834,902	27.09
27.10	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,237,502	1,604,855	2,842,357	27.10
27.11	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27.11
27.12	DRUGS CHARGED TO PATIENTS	5,625,699	2,771,934	8,397,633	27.12
27.13	CARDIAC REHAB	327	401,748	402,075	27.13
27.14	NURSING ADMIN	10,857	14,826	25,683	27.14
27.15	DIETARY	0	54,318	54,318	27.15
27.16	PHYSICIAN	0	573,937	573,937	27.16
27.17	NURSERY	271,869	0	271,869	27.17
27.18	EMERGENCY	4,464,523	18,213,211	22,677,734	27.18
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,498,373	114,642,588	166,140,961	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,134,471		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	EXPENSES IN OTHER OPERATION REV	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)		70,134,471		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 11/22/2013 9:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	166,140,961	1.00
2.00	Less contractual allowances and discounts on patients' accounts	95,204,724	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,936,237	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,134,471	4.00
5.00	Net income from service to patients (line 3 minus line 4)	801,766	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	63,975	6.00
7.00	Income from investments	6,984,743	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	CHANGE IN BENE. INT. PERPETUAL TRUST	229,462	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	315,321	24.02
24.03	INCREASE IN TEMP. RESTRICTED ASSETS	41,481	24.03
24.05	CHANGE IN FV OF INT. RATE SWAP AGREE	2,382,855	24.05
24.06	OTHER OPERATING REVENUE	4,345,528	24.06
24.07		0	24.07
25.00	Total other income (sum of lines 6-24)	14,363,365	25.00
26.00	Total (line 5 plus line 25)	15,165,131	26.00
27.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	4,515,420	27.00
27.01	CY CHANGE IN UNREALIZED GAINS	2,505,956	27.01
27.02		0	27.02
27.03		0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	7,021,376	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,143,755	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H | Date/Time Prepared: 11/22/2013 9:42 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	157,233	0	0	0	56,333	213,566	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	261,039	0	15,562	0	0	276,601	6.00
7.00	Physical Therapy	55,717	0	0	0	0	55,717	7.00
8.00	Occupational Therapy	5,736	0	0	0	0	5,736	8.00
9.00	Speech Pathology	0	0	0	0	972	972	9.00
10.00	Medical Social Services	19,264	0	0	0	0	19,264	10.00
11.00	Home Health Aide	40,251	0	0	0	0	40,251	11.00
12.00	Supplies (see instructions)	0	0	0	0	38,141	38,141	12.00
13.00	Drugs	0	0	0	0	157	157	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	39,541	0	0	0	0	39,541	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	578,781	0	15,562	0	95,603	689,946	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	4,909	218,475	-973	217,502			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	276,601	0	276,601			6.00
7.00	Physical Therapy	0	55,717	0	55,717			7.00
8.00	Occupational Therapy	0	5,736	0	5,736			8.00
9.00	Speech Pathology	0	972	0	972			9.00
10.00	Medical Social Services	0	19,264	0	19,264			10.00
11.00	Home Health Aide	0	40,251	0	40,251			11.00
12.00	Supplies (see instructions)	0	38,141	0	38,141			12.00
13.00	Drugs	0	157	0	157			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	39,541	0	39,541			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)	4,909	694,855	-973	693,882			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-1 Part I Date/Time Prepared: 11/22/2013 9:42 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	217,502	0	0	0	0	217,502	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	276,601	0	0	0	0	276,601	6.00
7.00	Physical Therapy	55,717	0	0	0	0	55,717	7.00
8.00	Occupational Therapy	5,736	0	0	0	0	5,736	8.00
9.00	Speech Pathology	972	0	0	0	0	972	9.00
10.00	Medical Social Services	19,264	0	0	0	0	19,264	10.00
11.00	Home Health Aide	40,251	0	0	0	0	40,251	11.00
12.00	Supplies (see instructions)	38,141	0	0	0	0	38,141	12.00
13.00	Drugs	157	0	0	0		157	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	39,541	0	0	0	0	39,541	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	693,882	0	0	0	0	693,882	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	217,502		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	126,289	402,890	6.00
7.00	Physical Therapy	25,439	81,156	7.00
8.00	Occupational Therapy	2,619	8,355	8.00
9.00	Speech Pathology	444	1,416	9.00
10.00	Medical Social Services	8,795	28,059	10.00
11.00	Home Health Aide	18,377	58,628	11.00
12.00	Supplies (see instructions)	17,414	55,555	12.00
13.00	Drugs	72	229	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	18,053	57,594	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)		693,882	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-1 Part II Date/Time Prepared: 11/22/2013 9:42 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	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	-217,502	476,380	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	276,601	6.00
7.00	Physical Therapy	0	0	0	0	0	55,717	7.00
8.00	Occupational Therapy	0	0	0	0	0	5,736	8.00
9.00	Speech Pathology	0	0	0	0	0	972	9.00
10.00	Medical Social Services	0	0	0	0	0	19,264	10.00
11.00	Home Health Aide	0	0	0	0	0	40,251	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	38,141	12.00
13.00	Drugs	0	0	0		0	157	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	39,541	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-217,502	476,380	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		217,502	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.456572	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I | Date/Time Prepared: 11/22/2013 9:42 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	0	0	17,012	110,344	127,356	1.00
2.00	Skilled Nursing Care	402,890	0	0	0	0	402,890	2.00
3.00	Physical Therapy	81,156	0	0	0	0	81,156	3.00
4.00	Occupational Therapy	8,355	0	0	0	0	8,355	4.00
5.00	Speech Pathology	1,416	0	0	0	0	1,416	5.00
6.00	Medical Social Services	28,059	0	0	0	0	28,059	6.00
7.00	Home Health Aide	58,628	0	0	0	0	58,628	7.00
8.00	Supplies (see instructions)	55,555	0	0	0	0	55,555	8.00
9.00	Drugs	229	0	0	0	0	229	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	57,594	0	0	0	0	57,594	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)	693,882	0	0	17,012	110,344	821,238	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	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	34,054	0	412	7,870	0	0	1.00
2.00	Skilled Nursing Care	107,729	0	0	0	0	0	2.00
3.00	Physical Therapy	21,700	0	0	0	0	0	3.00
4.00	Occupational Therapy	2,234	0	0	0	0	0	4.00
5.00	Speech Pathology	379	0	0	0	0	0	5.00
6.00	Medical Social Services	7,503	0	0	0	0	0	6.00
7.00	Home Health Aide	15,677	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	14,855	0	0	0	0	0	8.00
9.00	Drugs	61	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	15,400	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)	219,592	0	412	7,870	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: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I | Date/Time Prepared: 11/22/2013 9:42 am

HHA CCN: 147142 | Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	
		13.00	14.00	15.00	16.00	20.00	24.00	
1.00	Administrative and General	0	0	0	0	76,221	245,913	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	510,619	2.00
3.00	Physical Therapy	0	0	0	0	0	102,856	3.00
4.00	Occupational Therapy	0	0	0	0	0	10,589	4.00
5.00	Speech Pathology	0	0	0	0	0	1,795	5.00
6.00	Medical Social Services	0	0	0	0	0	35,562	6.00
7.00	Home Health Aide	0	0	0	0	0	74,305	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	70,410	8.00
9.00	Drugs	0	0	62	0	0	352	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	72,994	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	62	0	76,221	1,125,395	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	245,913					1.00
2.00	Skilled Nursing Care	0	510,619	142,775	653,394			2.00
3.00	Physical Therapy	0	102,856	28,760	131,616			3.00
4.00	Occupational Therapy	0	10,589	2,961	13,550			4.00
5.00	Speech Pathology	0	1,795	502	2,297			5.00
6.00	Medical Social Services	0	35,562	9,944	45,506			6.00
7.00	Home Health Aide	0	74,305	20,776	95,081			7.00
8.00	Supplies (see instructions)	0	70,410	19,687	90,097			8.00
9.00	Drugs	0	352	98	450			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	72,994	20,410	93,404			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,125,395	245,913	1,125,395			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.			0.279611				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: 140001 HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part II Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	16,926	539,541	0	127,356	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	402,890	2.00
3.00	Physical Therapy	0	0	0	0	0	81,156	3.00
4.00	Occupational Therapy	0	0	0	0	0	8,355	4.00
5.00	Speech Pathology	0	0	0	0	0	1,416	5.00
6.00	Medical Social Services	0	0	0	0	0	28,059	6.00
7.00	Home Health Aide	0	0	0	0	0	58,628	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	55,555	8.00
9.00	Drugs	0	0	0	0	0	229	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	57,594	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	16,926	539,541		821,238	20.00
21.00	Total cost to be allocated	0	0	17,012	110,344		219,592	21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.005081	0.204515		0.267391	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	884	208	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)	0	884	208	0	0	0	20.00
21.00	Total cost to be allocated	0	412	7,870	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.466063	37.836538	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

Period: From 07/01/2012 To 06/30/2013

Worksheet H-2 Part II Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)			
		14.00	15.00	16.00	20.00			
1.00	Administrative and General	0	0	0	36,950			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	21,818	157	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	21,818	157	0	36,950			20.00
21.00	Total cost to be allocated	0	62	0	76,221			21.00
22.00	Unit cost multiplier	0.000000	0.394904	0.000000	2.062815			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	653,394		653,394	3,757	173.91	1.00
2.00	Physical Therapy	3.00	131,616	0	131,616	709	185.64	2.00
3.00	Occupational Therapy	4.00	13,550	0	13,550	126	107.54	3.00
4.00	Speech Pathology	5.00	2,297	0	2,297	7	328.14	4.00
5.00	Medical Social Services	6.00	45,506		45,506	26	1,750.23	5.00
6.00	Home Health Aide	7.00	95,081		95,081	632	150.44	6.00
7.00	Total (sum of lines 1-6)		941,444	0	941,444	5,257		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	832	1,135			8.00
8.01	Skilled Nursing Care		37900	37	30			8.01
8.02	Skilled Nursing Care		44100	38	48			8.02
9.00	Physical Therapy		99914	217	169			9.00
9.01	Physical Therapy		37900	2	4			9.01
9.02	Physical Therapy		44100	0	0			9.02
10.00	Occupational Therapy		99914	38	31			10.00
10.01	Occupational Therapy		37900	0	0			10.01
10.02	Occupational Therapy		44100	0	0			10.02
11.00	Speech Pathology		99914	4	0			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		44100	0	0			11.02
12.00	Medical Social Services		99914	6	7			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		44100	0	0			12.02
13.00	Home Health Aide		99914	122	281			13.00
13.01	Home Health Aide		37900	0	24			13.01
13.02	Home Health Aide		44100	0	0			13.02
14.00	Total (sum of lines 8-13)			1,296	1,729			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	90,097	0	90,097	42,697	2.110148	15.00
16.00	Cost of Drugs	9.00	450	0	450	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	907	1,213		157,736	210,953		1.00
2.00	Physical Therapy	219	173		40,655	32,116		2.00
3.00	Occupational Therapy	38	31		4,087	3,334		3.00
4.00	Speech Pathology	4	0		1,313	0		4.00
5.00	Medical Social Services	6	7		10,501	12,252		5.00
6.00	Home Health Aide	122	305		18,354	45,884		6.00
7.00	Total (sum of lines 1-6)	1,296	1,729		232,646	304,539		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 11/22/2013 9:42 am

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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							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	368,689						1.00
2.00	Physical Therapy	72,771						2.00
3.00	Occupational Therapy	7,421						3.00
4.00	Speech Pathology	1,313						4.00
5.00	Medical Social Services	22,753						5.00
6.00	Home Health Aide	64,238						6.00
7.00	Total (sum of lines 1-6)	537,185						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: 140001 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part II | Date/Time Prepared: 11/22/2013 9:42 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.467744	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.281080	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.331588	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/22/2013 9:42 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	272,150	145,406	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)	272,150	145,406	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	272,150	145,406	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	183,067	226,331	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,665	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	6,163	17,203	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	186	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	618	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)	189,230	246,003	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	189,230	246,003	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	189,230	246,003	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	189,230	246,003	29.00
30.00	OTHER ADJUSTMENTS (SEQUESTRATION)	-708	-1,469	30.00
31.00	Subtotal (line 29 plus/minus line 30)	188,522	244,534	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	188,521	244,533	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	1	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-5 | Date/Time Prepared: 11/22/2013 9:42 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		188,521		244,533	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)		188,521		244,533	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		188,522		244,534	7.00

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K | Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	186,165	0	0	19,215	66,487	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	Total (sum of lines 1 thru 38)	186,165	0	0	19,215	66,487	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K | Date/Time Prepared: 11/22/2013 9:42 am

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		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	271,867	4,909	276,776	0	276,776	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	Total (sum of lines 1 thru 38)	271,867	4,909	276,776	0	276,776	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-1

Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	55,434	0	0	0	77,855	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	55,434	0	0	0	77,855	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-1

Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		9,819	43,057	186,165		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	9,819	43,057	186,165		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K-3 | Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	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						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K-3 | Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	19,215	19,215		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	19,215	19,215		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-4 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	276,776	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	Total (sum of lines 1 thru 38)	276,776	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-4 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0	0			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	276,776	0	276,776		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	276,776		276,776		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K-4 Part II Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2012 To 06/30/2013 | Worksheet K-4 Part II Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	0	276,776		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	276,776		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	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)		0		39.00
40.00	Unit Cost Multiplier		0.000000		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-5 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		0	0	6,282	46,099	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	276,776	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)	276,776	0	0	6,282	46,099	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-5 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	52,381	14,006	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	276,776	74,008	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)	329,157	88,014	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

Period:
From 07/01/2012
To 06/30/2013

Worksheet K-5
Part I
Date/Time Prepared:
11/22/2013 9:42 am

Hospice I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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	10,043	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	10,043	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-5 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	29,704	96,091			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	350,784	0	350,784	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	10,043	0	10,043	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	29,704	456,918	0	456,918	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-5 Part I Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	93,416	444,200		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	2,675	12,718		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		456,918		34.00
35.00	Unit Cost Multiplier (see instructions)	0.266308			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

Period:
From 07/01/2012
To 06/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 9:42 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	8,333	272,685	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	8,333	272,685		34.00
35.00	Total cost to be allocated	0	0	6,282	46,099		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.753870	0.169056		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

Period:
From 07/01/2012
To 06/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 9:42 am

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	52,381	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	276,776	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)	329,157	0	0	0	0	34.00
35.00	Total cost to be allocated	88,014	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.267392	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

Period:
From 07/01/2012
To 06/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 9:42 am

Hospice I

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
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	285	99,995	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	285	99,995	0	34.00
35.00	Total cost to be allocated	0	0	0	10,043	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.100435	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

Period:
From 07/01/2012
To 06/30/2013

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 9:42 am

Hospice I

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	19,000		1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	19,000		34.00
35.00	Total cost to be allocated	29,704		35.00
36.00	Unit Cost Multiplier (see instructions)	1.563368		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-5 Part III Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.467744	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.331588	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.529187	0	0	5.00
6.00	LABORATORY	60.00	0.221520	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.281080	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
10.97	CARDIAC REHABILITATION	76.97	1.251448	0	0	10.97
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140001 Hospice CCN: 141558

Period: From 07/01/2012 To 06/30/2013

Worksheet K-6

Date/Time Prepared: 11/22/2013 9:42 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				456,918	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,480	2.00
3.00	Average cost per diem (line 1 divided by line 2)				131.30	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	2,609				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	342,562				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		310			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		40,703			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			561		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			73,659		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140001	Period: From 07/01/2012 To 06/30/2013	Worksheet L Parts I-III Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	387,338	1.00
2.00	Capital DRG outlier payments	11,567	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.39	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	398,905	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/22/2013 9:42 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,680,404	0	1,680,404	-77,917	1,602,487	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	1,105,065	0	1,105,065	-7,929	1,097,136	9.00
10.00	Subtotal (sum of lines 1-9)	2,785,469	0	2,785,469	-85,846	2,699,623	10.00
11.00	Physician Services Under Agreement	0	7,411,981	7,411,981	-121,229	7,290,752	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	7,411,981	7,411,981	-121,229	7,290,752	14.00
15.00	Medical Supplies	0	171,348	171,348	-2,803	168,545	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	40,356	40,356	-660	39,696	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	211,704	211,704	-3,463	208,241	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,785,469	7,623,685	10,409,154	-210,538	10,198,616	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,295	4,295	-70	4,225	29.00
30.00	Administrative Costs	25,507	82,886	108,393	-1,553	106,840	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,507	87,181	112,688	-1,623	111,065	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,810,976	7,710,866	10,521,842	-212,161	10,309,681	32.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/22/2013 9:42 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,602,487		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,097,136		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,699,623		10.00
11.00	Physician Services Under Agreement	0	7,290,752		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	7,290,752		14.00
15.00	Medical Supplies	0	168,545		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	39,696		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	208,241		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	10,198,616		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-4,483	-258		29.00
30.00	Administrative Costs	-127,489	-20,649		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-131,972	-20,907		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-131,972	10,177,709		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-2 Date/Time Prepared: 11/22/2013 9:42 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	16.00	76,248	4,200	67,200		1.00
2.00	Physician Assistant	3.00	9,160	2,100	6,300		2.00
3.00	Nurse Practitioner	3.00	9,433	2,100	6,300		3.00
4.00	Subtotal (sum of lines 1-3)	22.00	94,841		79,800	94,841	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)	22.00	94,841			94,841	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					10,198,616	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)					10,198,616	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)					-20,907	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					5,059,354	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,038,447	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					5,038,447	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					5,038,447	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					15,237,063	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3 Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		15,237,063	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		88,770	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		15,148,293	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		94,841	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		94,841	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		159.72	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	159.72	159.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	17,796	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,842,377	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) *		2,842,377	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,650,016	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,689	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		24,336	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.)		2,067,700	16.04
16.05	Total program cost (see instructions)		2,092,036	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		233,416	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		478,777	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,092,036	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,594	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,113,630	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEQUESTRATION)		-11,528	25.00
26.00	Net reimbursable amount (see instructions)		2,102,102	26.00
26.01	Sequestration adjustment (see instructions)		10,511	26.01
27.00	Interim payments		1,948,780	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		142,811	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		37,402	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2012 To 06/30/2013	Worksheet M-4 Date/Time Prepared: 11/22/2013 9:42 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,699,623	2,699,623	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.006266	0.009875	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	16,916	26,659	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,215	8,626	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	24,131	35,285	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	10,198,616	10,198,616	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	5,038,447	5,038,447	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002366	0.003460	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	11,921	17,433	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	36,052	52,718	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,467	2,312	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	24.58	22.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	155	780	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,810	17,784	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)		88,770	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)		21,594	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2012 To 06/30/2013	Worksheet M-5 Date/Time Prepared: 11/22/2013 9:42 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,948,780	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)		1,948,780	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		153,322	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,102,102	7.00

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