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: 141311	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/26/2013 11:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/26/2013 Time: 11:10 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 FAIRFIELD MEMORIAL HOSPITAL (141311) 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	-221,524	-400,848	190	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	175	-5		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	-420	-792		0	9.00
10.00	RURAL HEALTH CLINIC I	0		65,570		0	10.00
200.00	Total	0	-221,769	-336,075	190	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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 11:06 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 NW 11TH STREET	PO Box:			1.00
2.00	City: FAIRFIELD	State: IL	Zip Code: 62837	County: WAYNE	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	FAIRFIELD MEMORIAL HOSPITAL	141311	14999	1	04/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	14999		03/26/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	14999		05/01/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	14999		03/13/2009	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.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 11:06 am

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

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

		V	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	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)	N			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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2013 11:06 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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/26/2013 11:06 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.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00

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

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

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

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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)	Y		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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	194,329	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)	07/01/2012	06/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2013 11:06 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	C	10/31/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/25/2013	Y	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)		N		N	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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/26/2013 11:06 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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 11:06 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)	10/25/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 11/26/2013 11:06 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	21	7,665	63,984.00	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)		21	7,665	63,984.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	6,984.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	70,968.00	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	30	10,950		0	19.00
20.00	NURSING FACILITY	45.00	0	0		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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		55				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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2013 11:06 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)	2,024	201	2,666			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	2,024	201	2,666			7.00
8.00	INTENSIVE CARE UNIT	188	28	291			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	2,212	229	2,957	0.00	166.75	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	1,494	0	6,788	0.00	19.14	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,829	0	3,545	0.00	4.71	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	7,203	0	20,901	0.00	26.83	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	217.43	27.00
28.00	Observation Bed Days		0	1,099			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/26/2013 11:06 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	614	64	842	1.00
2.00	HMO and other (see instructions)			0			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	614	64	842	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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part IV Date/Time Prepared: 11/26/2013 11:06 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	131,195	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	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,308,048	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)	40,938	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	163,830	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	702,455	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	13,312	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,359,778	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141311 | Component CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-4 | Date/Time Prepared: 11/26/2013 11:06 am

Home Health Agency I | PPS

		1.00	
0.00	County	WAYNE	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	133.00	0.00	42.00	175.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1				19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		14999				20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,375	306	48	8	1,737	21.00
22.00	Skilled Nursing Visit Charges	143,110	33,110	4,840	770	181,830	22.00
23.00	Physical Therapy Visits	767	39	2	8	816	23.00
24.00	Physical Therapy Visit Charges	83,270	4,290	220	880	88,660	24.00
25.00	Occupational Therapy Visits	179	19	2	5	205	25.00
26.00	Occupational Therapy Visit Charges	19,470	2,090	220	550	22,330	26.00
27.00	Speech Pathology Visits	67	4	0	0	71	27.00
28.00	Speech Pathology Visit Charges	7,360	460	0	0	7,820	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,388	368	52	21	2,829	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)	253,210	39,950	5,280	2,200	300,640	35.00
36.00	Total Number of Episodes (standard/non outlier)	151		17	2	170	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	70,754	7,341	1,568	0	79,663	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/26/2013 11:06 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.	N		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	44	0	44	3.00
4.00		RUL	9	0	9	4.00
5.00		RVX	14	0	14	5.00
6.00		RVL	69	0	69	6.00
7.00		RHX	14	0	14	7.00
8.00		RHL	40	0	40	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	13	0	13	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	118	0	118	12.00
13.00		RUB	54	0	54	13.00
14.00		RUA	110	0	110	14.00
15.00		RVC	94	0	94	15.00
16.00		RVB	65	0	65	16.00
17.00		RVA	247	0	247	17.00
18.00		RHC	63	0	63	18.00
19.00		RHB	75	0	75	19.00
20.00		RHA	133	0	133	20.00
21.00		RMC	26	0	26	21.00
22.00		RMB	14	0	14	22.00
23.00		RMA	108	0	108	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	14	0	14	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	9	0	9	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	7	0	7	32.00
33.00		HC2	12	0	12	33.00
34.00		HC1	8	0	8	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	13	0	13	36.00
37.00		LE2	6	0	6	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	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	2	0	2	46.00
47.00		CD2	17	0	17	47.00
48.00		CD1	26	0	26	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	31	0	31	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	13	0	13	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	22	0	22	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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/26/2013 11:06 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	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	4	0	4	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,494	0	1,494	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).	14999	14999	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	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		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)	904,450			207.00

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

Provider CCN: 141311 Component CCN: 148500 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 11/26/2013 11:06 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	303 NW 11TH STREET	1.00
		City: 1.00	State: 2.00	Zip Code: 3.00
2.00	City, State, Zip Code, County	FAIRFIELD	IL	62837	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award: 1.00	Date: 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: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	05:00	09:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00

		Provider name: 1.00	CCN number: 2.00	
14.00	Provider name, CCN number	FAIRFIELD RHC	148500	14.00

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

			County: 4.00				
2.00	City, State, Zip Code, County		WAYNE				2.00

		Tuesday	Wednesday		Thursday		
		to: 6.00	from: 7.00	to: 8.00	from: 9.00	to: 10.00	
	Facility hours of operations (1)						
11.00	Clinic	05:00	09:00	05:00	09:00	05:00	11.00

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

Provider CCN: 141311
Component CCN: 148500

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

Worksheet S-8

Date/Time Prepared:
11/26/2013 11:06 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 11/26/2013 11:06 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)	0.378508	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,836,626	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	1,882,812	5.00
6.00	Medicaid charges	9,643,934	6.00
7.00	Medicaid cost (line 1 times line 6)	3,650,306	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,414,094	136,572	2,550,666	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	913,754	51,694	965,448	21.00
22.00	Partial payment by patients approved for charity care	1,337	2,227	3,564	22.00
23.00	Cost of charity care (line 21 minus line 22)	912,417	49,467	961,884	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)	2,028,251	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	853,704	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	1,174,547	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	444,575	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,406,459	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,406,459	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/26/2013 11:06 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		1,336,105	1,336,105	385,610	1,721,715	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	325,328	325,328	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92,341	2,375,504	2,467,845	0	2,467,845	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	918,835	2,086,222	3,005,057	-8,197	2,996,860	5.00
6.00	00600	MAINTENANCE & REPAIRS	279,000	344,074	623,074	-545	622,529	6.00
7.00	00700	OPERATION OF PLANT	0	568,046	568,046	0	568,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	400,581	400,581	0	400,581	8.00
9.00	00900	HOUSEKEEPING	314,054	145,911	459,965	0	459,965	9.00
10.00	01000	DIETARY	49,963	774,550	824,513	-353,017	471,496	10.00
11.00	01100	CAFETERIA	0	0	0	353,017	353,017	11.00
13.00	01300	NURSING ADMINISTRATION	212,328	19,396	231,724	0	231,724	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	253,361	60,898	314,259	0	314,259	16.00
17.00	01700	SOCIAL SERVICE	87,284	8,186	95,470	0	95,470	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,167,056	62,364	1,229,420	-213	1,229,207	30.00
31.00	03100	INTENSIVE CARE UNIT	216,243	5,827	222,070	0	222,070	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	617,023	37,864	654,887	-1,572	653,315	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	996,271	315,493	1,311,764	-60,251	1,251,513	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	382,069	1,153,855	1,535,924	-129,917	1,406,007	54.00
60.00	06000	LABORATORY	785,971	1,193,829	1,979,800	-109,185	1,870,615	60.00
65.00	06500	RESPIRATORY THERAPY	166,138	128,141	294,279	-109,516	184,763	65.00
66.00	06600	PHYSICAL THERAPY	603,916	12,250	616,166	0	616,166	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	96,234	96,234	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,736	749,886	795,622	-49,205	746,417	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	49,205	49,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	198,209	940,379	1,138,588	0	1,138,588	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,174,760	273,232	2,447,992	-2,166	2,445,826	88.00
90.00	09000	CLINIC	203,582	130,040	333,622	0	333,622	90.00
90.01	09001	WOUND CARE	2,802	57,250	60,052	0	60,052	90.01
91.00	09100	EMERGENCY	540,090	1,570,786	2,110,876	0	2,110,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	235,577	62,593	298,170	0	298,170	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		401,125	401,125	-385,610	15,515	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,542,609	15,214,387	25,756,996	0	25,756,996	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	10,542,609	15,214,387	25,756,996	0	25,756,996	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/26/2013 11:06 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	-323,404	1,398,311		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	325,328		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,467,845		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-840,463	2,156,397		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	622,529		6.00
7.00	00700	OPERATION OF PLANT	0	568,046		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	400,581		8.00
9.00	00900	HOUSEKEEPING	0	459,965		9.00
10.00	01000	DIETARY	0	471,496		10.00
11.00	01100	CAFETERIA	-106,531	246,486		11.00
13.00	01300	NURSING ADMINISTRATION	0	231,724		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,165	305,094		16.00
17.00	01700	SOCIAL SERVICE	0	95,470		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,229,207		30.00
31.00	03100	INTENSIVE CARE UNIT	0	222,070		31.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	653,315		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-507,438	744,075		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,173	1,407,180		54.00
60.00	06000	LABORATORY	0	1,870,615		60.00
65.00	06500	RESPIRATORY THERAPY	0	184,763		65.00
66.00	06600	PHYSICAL THERAPY	0	616,166		66.00
69.00	06900	ELECTROCARDIOLOGY	-52,494	43,740		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	746,417		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	49,205		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,138,588		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,445,826		88.00
90.00	09000	CLINIC	0	333,622		90.00
90.01	09001	WOUND CARE	0	60,052		90.01
91.00	09100	EMERGENCY	-1,032,986	1,077,890		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	298,170		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-15,515	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,886,823	22,870,173		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	DR. OFFICE	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,886,823	22,870,173		200.00

RECLASSIFICATIONS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/26/2013 11:06 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	21,392	331,625		1.00
	TOTALS		21,392	331,625		
	C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	43,740	52,494		1.00
	TOTALS		43,740	52,494		
	D - RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	325,328		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
22.00		0.00	0	0		22.00
	TOTALS		0	325,328		
	E - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	385,610		1.00
	TOTALS		0	385,610		
	F - IMPLANTABLE DEVICE					
1.00	IMP. DEV CHARGED TO PATIENT	72.00	0	49,205		1.00
	TOTALS		0	49,205		
500.00	Grand Total: Increases		65,132	1,144,262		500.00

RECLASSIFICATIONS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/26/2013 11:06 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	21,392	331,625	0		1.00
	TOTALS		21,392	331,625			
	C - EKG						
1.00	RESPIRATORY THERAPY	65.00	43,740	52,494	0		1.00
	TOTALS		43,740	52,494			
	D - RENTAL						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,197	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	545	0		3.00
11.00	ADULTS & PEDIATRICS	30.00	0	213	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,572	0		12.00
13.00	OPERATING ROOM	50.00	0	60,251	0		13.00
14.00	RADIOLOGY - DIAGNOSTIC	54.00	0	129,917	0		14.00
15.00	LABORATORY	60.00	0	109,185	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	13,282	0		16.00
22.00	RURAL HEALTH CLINIC	88.00	0	2,166	0		22.00
	TOTALS		0	325,328			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	385,610	9		1.00
	TOTALS		0	385,610			
	F - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	49,205	0		1.00
	TOTALS		0	49,205			
500.00	Grand Total: Decreases		65,132	1,144,262			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 11/26/2013 11:06 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	421,395	0	0	0	0	1.00
2.00	Land Improvements	640,428	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,853,152	40,402	0	40,402	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	741,400	487,838	0	487,838	0	5.00
6.00	Movable Equipment	9,001,224	103,072	0	103,072	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,657,599	631,312	0	631,312	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,657,599	631,312	0	631,312	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	421,395	0	1.00
2.00	Land Improvements	640,428	0	2.00
3.00	Buildings and Fixtures	22,893,554	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,229,238	0	5.00
6.00	Movable Equipment	9,104,296	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,288,911	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,288,911	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 11/26/2013 11:06 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	1,336,105	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,336,105	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	1,336,105	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,336,105	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 11/26/2013 11:06 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,336,105	0	1,336,105	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,336,105	0	1,336,105	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,398,311	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	325,328	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,723,639	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	0	0	0	0	1,398,311	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	325,328	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,723,639	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/26/2013 11:06 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
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-15,515	INTEREST EXPENSE	113.00	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)	A	-2,348	ADMINISTRATIVE & GENERAL	5.00	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	-1,592,918			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-443	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,173			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-106,531	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,165	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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
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	A	-53,106	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	OFFICE SPACE RENTAL	B	-91,936	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	RINARD & WEBER CLINIC	A	-28,362	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/26/2013 11:06 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	
33.02	RECRUITING	A	-58,800	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-118,221	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER REVENUE	B	-148,304	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	WAYFAIR RENTAL	B	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	PROVIDER TAX EXPENSE	A	-512,347	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	0	33.07
33.08			0		0.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,886,823				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-1 | Date/Time Prepared: 11/26/2013 11:06 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY - DIAGNOSTIC	MRI	247,716	246,543	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	247,716	246,543	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141311	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-1 Date/Time Prepared: 11/26/2013 11:06 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,173	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1,173			5.00

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

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

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

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

6.00	MRI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 11/26/2013 11:06 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	50.00	OPERATING ROOM	507,438	507,438	0	0	0	1.00
2.00	60.00	LABORATORY	26,371	0	26,371	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	52,494	52,494	0	0	0	3.00
4.00	91.00	EMERGENCY	1,436,499	1,032,986	403,513	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,022,802	1,592,918	429,884		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	507,438		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	52,494		3.00
4.00	91.00	EMERGENCY	0	0	0	1,032,986		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,592,918		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,398,311	1,398,311				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	325,328		325,328			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,467,845	0	0	2,467,845		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,156,397	294,420	68,499	216,984	2,736,300	5.00
6.00	00600	MAINTENANCE & REPAIRS	622,529	40,167	9,345	65,886	737,927	6.00
7.00	00700	OPERATION OF PLANT	568,046	26,253	6,108	0	600,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	400,581	18,141	4,221	0	422,943	8.00
9.00	00900	HOUSEKEEPING	459,965	2,510	584	74,164	537,223	9.00
10.00	01000	DIETARY	471,496	6,595	1,534	6,747	486,372	10.00
11.00	01100	CAFETERIA	246,486	7,021	1,633	5,052	260,192	11.00
13.00	01300	NURSING ADMINISTRATION	231,724	1,815	422	50,141	284,102	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	305,094	15,687	3,650	59,831	384,262	16.00
17.00	01700	SOCIAL SERVICE	95,470	2,269	528	20,612	118,879	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,229,207	207,063	48,175	275,601	1,760,046	30.00
31.00	03100	INTENSIVE CARE UNIT	222,070	18,906	4,399	51,066	296,441	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	653,315	121,310	28,224	145,711	948,560	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	744,075	92,078	21,423	235,270	1,092,846	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,407,180	64,932	15,107	90,226	1,577,445	54.00
60.00	06000	LABORATORY	1,870,615	32,168	7,484	185,608	2,095,875	60.00
65.00	06500	RESPIRATORY THERAPY	184,763	23,885	5,557	28,904	243,109	65.00
66.00	06600	PHYSICAL THERAPY	616,166	51,188	11,909	142,615	821,878	66.00
69.00	06900	ELECTROCARDIOLOGY	43,740	0	0	10,329	54,069	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,417	25,190	5,861	10,801	788,269	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	49,205	0	0	0	49,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,138,588	38,692	9,002	46,807	1,233,089	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,445,826	210,425	48,957	513,577	3,218,785	88.00
90.00	09000	CLINIC	333,622	24,608	5,725	48,076	412,031	90.00
90.01	09001	WOUND CARE	60,052	12,822	2,983	662	76,519	90.01
91.00	09100	EMERGENCY	1,077,890	32,934	7,662	127,543	1,246,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	298,170	27,232	6,336	55,632	387,370	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,870,173	1,398,311	325,328	2,467,845	22,870,173	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,870,173	1,398,311	325,328	2,467,845	22,870,173	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,736,300					5.00
6.00	00600	MAINTENANCE & REPAIRS	100,288	838,215				6.00
7.00	00700	OPERATION OF PLANT	81,598	20,688	702,693			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	57,480	14,295	12,287	507,005		8.00
9.00	00900	HOUSEKEEPING	73,011	1,978	1,700	43,388	657,300	9.00
10.00	01000	DIETARY	66,100	5,197	4,467	0	4,263	10.00
11.00	01100	CAFETERIA	35,361	5,532	4,755	0	4,538	11.00
13.00	01300	NURSING ADMINISTRATION	38,611	1,431	1,230	0	1,174	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,223	12,361	10,625	0	10,140	16.00
17.00	01700	SOCIAL SERVICE	16,156	1,788	1,537	0	1,467	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	239,199	163,166	140,247	56,800	133,851	30.00
31.00	03100	INTENSIVE CARE UNIT	40,288	14,898	12,806	1,738	12,222	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	128,914	95,593	82,165	57,481	78,418	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,523	72,558	62,366	24,318	59,522	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	214,383	51,166	43,979	14,758	41,973	54.00
60.00	06000	LABORATORY	284,840	25,348	21,788	255,131	20,794	60.00
65.00	06500	RESPIRATORY THERAPY	33,040	18,821	16,177	4,669	15,440	65.00
66.00	06600	PHYSICAL THERAPY	111,697	40,336	34,670	11,418	33,089	66.00
69.00	06900	ELECTROCARDIOLOGY	7,348	0	0	1,363	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,130	19,849	17,061	0	16,283	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	6,687	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,583	30,489	26,207	0	25,012	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	437,456	165,815	142,524	8,214	136,026	88.00
90.00	09000	CLINIC	55,997	19,391	16,667	0	15,907	90.00
90.01	09001	WOUND CARE	10,399	10,104	8,684	0	8,288	90.01
91.00	09100	EMERGENCY	169,342	25,952	22,306	27,727	21,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	52,646	21,459	18,445	0	17,604	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,736,300	838,215	702,693	507,005	657,300	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	2,736,300	838,215	702,693	507,005	657,300	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	566,399					10.00
11.00	01100	CAFETERIA	0	310,378				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,623	332,171			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,142	0	485,753		16.00
17.00	01700	SOCIAL SERVICE	0	5,011	0	0	144,838	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,952	53,012	127,029	44,499	144,838	30.00
31.00	03100	INTENSIVE CARE UNIT	16,911	7,636	18,297	3,509	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	394,536	35,349	84,705	7,337	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,443	46,590	30,001	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	15,641	0	108,276	0	54.00
60.00	06000	LABORATORY	0	37,074	0	92,843	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,425	0	28,979	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,197	0	21,476	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,939	0	10,192	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,489	0	31,493	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	1,262	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,803	0	48,658	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	49,531	0	25,315	0	88.00
90.00	09000	CLINIC	0	8,860	0	7,756	0	90.00
90.01	09001	WOUND CARE	0	21	0	1,518	0	90.01
91.00	09100	EMERGENCY	0	23,182	55,550	22,639	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	566,399	310,378	332,171	485,753	144,838	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	566,399	310,378	332,171	485,753	144,838	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,017,639	0	3,017,639		30.00
31.00	03100	INTENSIVE CARE UNIT	424,746	0	424,746		31.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,913,058	0	1,913,058		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,556,167	0	1,556,167		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,067,621	0	2,067,621		54.00
60.00	06000	LABORATORY	2,833,693	0	2,833,693		60.00
65.00	06500	RESPIRATORY THERAPY	365,660	0	365,660		65.00
66.00	06600	PHYSICAL THERAPY	1,091,761	0	1,091,761		66.00
69.00	06900	ELECTROCARDIOLOGY	74,911	0	74,911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	983,574	0	983,574		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	57,154	0	57,154		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,841	0	1,536,841		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,183,666	0	4,183,666		88.00
90.00	09000	CLINIC	536,609	0	536,609		90.00
90.01	09001	WOUND CARE	115,533	0	115,533		90.01
91.00	09100	EMERGENCY	1,614,016	0	1,614,016		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	497,524	0	497,524		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,870,173	0	22,870,173		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	DR. OFFICE	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	22,870,173	0	22,870,173		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	294,420	68,499	362,919	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	40,167	9,345	49,512	0	6.00
7.00	00700	OPERATION OF PLANT	0	26,253	6,108	32,361	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,141	4,221	22,362	0	8.00
9.00	00900	HOUSEKEEPING	0	2,510	584	3,094	0	9.00
10.00	01000	DIETARY	0	6,595	1,534	8,129	0	10.00
11.00	01100	CAFETERIA	0	7,021	1,633	8,654	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,815	422	2,237	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,687	3,650	19,337	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,269	528	2,797	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	207,063	48,175	255,238	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,906	4,399	23,305	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	121,310	28,224	149,534	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	92,078	21,423	113,501	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	64,932	15,107	80,039	0	54.00
60.00	06000	LABORATORY	0	32,168	7,484	39,652	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,885	5,557	29,442	0	65.00
66.00	06600	PHYSICAL THERAPY	0	51,188	11,909	63,097	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,190	5,861	31,051	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,692	9,002	47,694	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	210,425	48,957	259,382	0	88.00
90.00	09000	CLINIC	0	24,608	5,725	30,333	0	90.00
90.01	09001	WOUND CARE	0	12,822	2,983	15,805	0	90.01
91.00	09100	EMERGENCY	0	32,934	7,662	40,596	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	27,232	6,336	33,568	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,398,311	325,328	1,723,639	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,398,311	325,328	1,723,639	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	362,919					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,301	62,813				6.00
7.00	00700	OPERATION OF PLANT	10,822	1,550	44,733			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,624	1,071	782	31,839		8.00
9.00	00900	HOUSEKEEPING	9,683	148	108	2,725	15,758	9.00
10.00	01000	DIETARY	8,767	389	284	0	102	10.00
11.00	01100	CAFETERIA	4,690	415	303	0	109	11.00
13.00	01300	NURSING ADMINISTRATION	5,121	107	78	0	28	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,926	926	676	0	243	16.00
17.00	01700	SOCIAL SERVICE	2,143	134	98	0	35	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,725	12,227	8,928	3,567	3,209	30.00
31.00	03100	INTENSIVE CARE UNIT	5,343	1,116	815	109	293	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17,098	7,163	5,231	3,610	1,880	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,699	5,437	3,970	1,527	1,427	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	28,433	3,834	2,800	927	1,006	54.00
60.00	06000	LABORATORY	37,778	1,900	1,387	16,021	499	60.00
65.00	06500	RESPIRATORY THERAPY	4,382	1,410	1,030	293	370	65.00
66.00	06600	PHYSICAL THERAPY	14,814	3,023	2,207	717	793	66.00
69.00	06900	ELECTROCARDIOLOGY	975	0	0	86	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,209	1,487	1,086	0	390	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	887	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,226	2,285	1,668	0	600	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	58,025	12,428	9,074	516	3,262	88.00
90.00	09000	CLINIC	7,427	1,453	1,061	0	381	90.00
90.01	09001	WOUND CARE	1,379	757	553	0	199	90.01
91.00	09100	EMERGENCY	22,460	1,945	1,420	1,741	510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,982	1,608	1,174	0	422	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,919	62,813	44,733	31,839	15,758	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	362,919	62,813	44,733	31,839	15,758	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	17,671					10.00
11.00	01100	CAFETERIA	0	14,171				11.00
13.00	01300	NURSING ADMINISTRATION	0	257	7,828			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	737	0	28,845		16.00
17.00	01700	SOCIAL SERVICE	0	229	0	0	5,436	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,834	2,419	2,994	2,644	5,436	30.00
31.00	03100	INTENSIVE CARE UNIT	528	349	431	208	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	12,309	1,614	1,996	436	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	888	1,098	1,783	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	714	0	6,416	0	54.00
60.00	06000	LABORATORY	0	1,693	0	5,517	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	248	0	1,722	0	65.00
66.00	06600	PHYSICAL THERAPY	0	785	0	1,276	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	89	0	606	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	159	0	1,871	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	75	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	265	0	2,891	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,261	0	1,504	0	88.00
90.00	09000	CLINIC	0	405	0	461	0	90.00
90.01	09001	WOUND CARE	0	1	0	90	0	90.01
91.00	09100	EMERGENCY	0	1,058	1,309	1,345	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,671	14,171	7,828	28,845	5,436	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	17,671	14,171	7,828	28,845	5,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	333,221	0	333,221		30.00
31.00	03100	INTENSIVE CARE UNIT	32,497	0	32,497		31.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	200,871	0	200,871		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	149,330	0	149,330		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	124,169	0	124,169		54.00
60.00	06000	LABORATORY	104,447	0	104,447		60.00
65.00	06500	RESPIRATORY THERAPY	38,897	0	38,897		65.00
66.00	06600	PHYSICAL THERAPY	86,712	0	86,712		66.00
69.00	06900	ELECTROCARDIOLOGY	1,756	0	1,756		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,253	0	50,253		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	962	0	962		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,629	0	77,629		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	346,452	0	346,452		88.00
90.00	09000	CLINIC	41,521	0	41,521		90.00
90.01	09001	WOUND CARE	18,784	0	18,784		90.01
91.00	09100	EMERGENCY	72,384	0	72,384		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	43,754	0	43,754		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,723,639	0	1,723,639		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	DR. OFFICE	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,723,639	0	1,723,639		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	98,588					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,588				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,450,268			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,758	20,758	918,835	-2,736,300	20,133,873	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,832	2,832	279,000	0	737,927	6.00
7.00	00700	OPERATION OF PLANT	1,851	1,851	0	0	600,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	422,943	8.00
9.00	00900	HOUSEKEEPING	177	177	314,054	0	537,223	9.00
10.00	01000	DIETARY	465	465	28,571	0	486,372	10.00
11.00	01100	CAFETERIA	495	495	21,392	0	260,192	11.00
13.00	01300	NURSING ADMINISTRATION	128	128	212,328	0	284,102	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,106	1,106	253,361	0	384,262	16.00
17.00	01700	SOCIAL SERVICE	160	160	87,284	0	118,879	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,599	14,599	1,167,056	0	1,760,046	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	216,243	0	296,441	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	617,023	0	948,560	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,492	6,492	996,271	0	1,092,846	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,578	4,578	382,069	0	1,577,445	54.00
60.00	06000	LABORATORY	2,268	2,268	785,971	0	2,095,875	60.00
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	122,398	0	243,109	65.00
66.00	06600	PHYSICAL THERAPY	3,609	3,609	603,916	0	821,878	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	43,740	0	54,069	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	45,736	0	788,269	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	49,205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	198,209	0	1,233,089	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,836	14,836	2,174,760	0	3,218,785	88.00
90.00	09000	CLINIC	1,735	1,735	203,582	0	412,031	90.00
90.01	09001	WOUND CARE	904	904	2,802	0	76,519	90.01
91.00	09100	EMERGENCY	2,322	2,322	540,090	0	1,246,029	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	235,577	0	387,370	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,588	98,588	10,450,268	-2,736,300	20,133,873	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	1,398,311	325,328	2,467,845		2,736,300	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.183379	3.299874	0.236151		0.135905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		362,919	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.018025	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	74,998					6.00
7.00	00700	OPERATION OF PLANT	1,851	73,147				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	1,279	29,751			8.00
9.00	00900	HOUSEKEEPING	177	177	2,546	71,691		9.00
10.00	01000	DIETARY	465	465	0	465	35,570	10.00
11.00	01100	CAFETERIA	495	495	0	495	0	11.00
13.00	01300	NURSING ADMINISTRATION	128	128	0	128	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,106	1,106	0	1,106	0	16.00
17.00	01700	SOCIAL SERVICE	160	160	0	160	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,599	14,599	3,333	14,599	9,731	30.00
31.00	03100	INTENSIVE CARE UNIT	1,333	1,333	102	1,333	1,062	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,553	8,553	3,373	8,553	24,777	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,492	6,492	1,427	6,492	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	4,578	4,578	866	4,578	0	54.00
60.00	06000	LABORATORY	2,268	2,268	14,971	2,268	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,684	1,684	274	1,684	0	65.00
66.00	06600	PHYSICAL THERAPY	3,609	3,609	670	3,609	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	80	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	0	1,776	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	0	2,728	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,836	14,836	482	14,836	0	88.00
90.00	09000	CLINIC	1,735	1,735	0	1,735	0	90.00
90.01	09001	WOUND CARE	904	904	0	904	0	90.01
91.00	09100	EMERGENCY	2,322	2,322	1,627	2,322	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,920	1,920	0	1,920	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,998	73,147	29,751	71,691	35,570	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
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)	838,215	702,693	507,005	657,300	566,399	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.176498	9.606587	17.041612	9.168515	15.923503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,813	44,733	31,839	15,758	17,671	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.837529	0.611549	1.070183	0.219804	0.496795	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/26/2013 11:06 am

		Cost Center Description	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			11.00	13.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	349,539					11.00
13.00	01300	NURSING ADMINISTRATION	6,332	156,112				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,179	0	59,877,748			16.00
17.00	01700	SOCIAL SERVICE	5,643	0	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,701	59,701	5,485,543	100		30.00
31.00	03100	INTENSIVE CARE UNIT	8,599	8,599	432,550	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	39,809	39,809	904,450	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,896	21,896	3,698,292	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	17,614	0	13,344,820	0		54.00
60.00	06000	LABORATORY	41,752	0	11,445,139	0		60.00
65.00	06500	RESPIRATORY THERAPY	6,110	0	3,572,311	0		65.00
66.00	06600	PHYSICAL THERAPY	19,367	0	2,647,393	0		66.00
69.00	06900	ELECTROCARDIOLOGY	2,184	0	1,256,439	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,929	0	3,882,258	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	155,569	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,535	0	5,998,252	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,780	0	3,120,736	0		88.00
90.00	09000	CLINIC	9,978	0	956,134	0		90.00
90.01	09001	WOUND CARE	24	0	187,118	0		90.01
91.00	09100	EMERGENCY	26,107	26,107	2,790,744	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	349,539	156,112	59,877,748	100		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	DR. OFFICE	0	0	0	0		194.00
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)	310,378	332,171	485,753	144,838		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.887964	2.127774	0.008112	1,448.380000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,171	7,828	28,845	5,436		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040542	0.050143	0.000482	54.360000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,017,639		3,017,639	0	3,017,639	30.00
31.00	03100	INTENSIVE CARE UNIT	424,746		424,746	0	424,746	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,913,058		1,913,058	0	1,913,058	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,556,167		1,556,167	0	1,556,167	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,067,621		2,067,621	0	2,067,621	54.00
60.00	06000	LABORATORY	2,833,693		2,833,693	0	2,833,693	60.00
65.00	06500	RESPIRATORY THERAPY	365,660	0	365,660	0	365,660	65.00
66.00	06600	PHYSICAL THERAPY	1,091,761	0	1,091,761	0	1,091,761	66.00
69.00	06900	ELECTROCARDIOLOGY	74,911		74,911	0	74,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	983,574		983,574	0	983,574	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	57,154		57,154	0	57,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,841		1,536,841	0	1,536,841	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,183,666		4,183,666	0	4,183,666	88.00
90.00	09000	CLINIC	536,609		536,609	0	536,609	90.00
90.01	09001	WOUND CARE	115,533		115,533	0	115,533	90.01
91.00	09100	EMERGENCY	1,614,016		1,614,016	0	1,614,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	880,849		880,849		880,849	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	497,524		497,524		497,524	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,751,022	0	23,751,022	0	23,751,022	200.00
201.00		Less Observation Beds	880,849		880,849		880,849	201.00
202.00		Total (see instructions)	22,870,173	0	22,870,173	0	22,870,173	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		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	4,475,569		4,475,569			30.00
31.00	03100	INTENSIVE CARE UNIT	432,550		432,550			31.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	904,450		904,450			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	380,526	3,317,766	3,698,292	0.420780	0.000000	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,035,831	12,308,989	13,344,820	0.154938	0.000000	54.00
60.00	06000	LABORATORY	1,611,250	9,833,889	11,445,139	0.247589	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	803,761	1,562,178	2,365,939	0.154552	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,043,174	1,604,219	2,647,393	0.412391	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	217,920	1,038,519	1,256,439	0.059622	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,889,391	3,199,239	5,088,630	0.193289	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	4,238	151,331	155,569	0.367387	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,685,070	4,313,182	5,998,252	0.256215	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,120,736	3,120,736			88.00
90.00	09000	CLINIC	0	956,134	956,134	0.561228	0.000000	90.00
90.01	09001	WOUND CARE	0	187,118	187,118	0.617434	0.000000	90.01
91.00	09100	EMERGENCY	76,864	2,713,880	2,790,744	0.578346	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,756	906,218	1,009,974	0.872150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	544,206	544,206			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,664,350	45,757,604	60,421,954			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,664,350	45,757,604	60,421,954			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		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	0.000000		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,017,639		3,017,639	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	424,746		424,746	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,913,058		1,913,058	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,556,167		1,556,167	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	2,067,621		2,067,621	0	0	54.00
60.00	06000	LABORATORY	2,833,693		2,833,693	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	365,660	0	365,660	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,091,761	0	1,091,761	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	74,911		74,911	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	983,574		983,574	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	57,154		57,154	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,536,841		1,536,841	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,183,666		4,183,666	0	0	88.00
90.00	09000	CLINIC	536,609		536,609	0	0	90.00
90.01	09001	WOUND CARE	115,533		115,533	0	0	90.01
91.00	09100	EMERGENCY	1,614,016		1,614,016	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	880,849		880,849		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	497,524		497,524		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,751,022	0	23,751,022	0	0	200.00
201.00		Less Observation Beds	880,849		880,849		0	201.00
202.00		Total (see instructions)	22,870,173	0	22,870,173	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		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	4,475,569		4,475,569			30.00
31.00	03100	INTENSIVE CARE UNIT	432,550		432,550			31.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	904,450		904,450			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	380,526	3,317,766	3,698,292	0.420780	0.000000	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,035,831	12,308,989	13,344,820	0.154938	0.000000	54.00
60.00	06000	LABORATORY	1,611,250	9,833,889	11,445,139	0.247589	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	803,761	1,562,178	2,365,939	0.154552	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,043,174	1,604,219	2,647,393	0.412391	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	217,920	1,038,519	1,256,439	0.059622	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,889,391	3,199,239	5,088,630	0.193289	0.000000	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	4,238	151,331	155,569	0.367387	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,685,070	4,313,182	5,998,252	0.256215	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,120,736	3,120,736	1.340602	0.000000	88.00
90.00	09000	CLINIC	0	956,134	956,134	0.561228	0.000000	90.00
90.01	09001	WOUND CARE	0	187,118	187,118	0.617434	0.000000	90.01
91.00	09100	EMERGENCY	76,864	2,713,880	2,790,744	0.578346	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	103,756	906,218	1,009,974	0.872150	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	544,206	544,206			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,664,350	45,757,604	60,421,954			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,664,350	45,757,604	60,421,954			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		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	0.000000		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,330	3,698,292	0.040378	171,375	6,920	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	124,169	13,344,820	0.009305	938,635	8,734	54.00
60.00	06000	LABORATORY	104,447	11,445,139	0.009126	1,389,617	12,682	60.00
65.00	06500	RESPIRATORY THERAPY	38,897	2,365,939	0.016440	470,873	7,741	65.00
66.00	06600	PHYSICAL THERAPY	86,712	2,647,393	0.032754	204,099	6,685	66.00
69.00	06900	ELECTROCARDIOLOGY	1,756	1,256,439	0.001398	191,254	267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,253	5,088,630	0.009876	1,170,114	11,556	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	962	155,569	0.006184	4,238	26	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,629	5,998,252	0.012942	1,312,316	16,984	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	346,452	3,120,736	0.111016	0	0	88.00
90.00	09000	CLINIC	41,521	956,134	0.043426	0	0	90.00
90.01	09001	WOUND CARE	18,784	187,118	0.100386	0	0	90.01
91.00	09100	EMERGENCY	72,384	2,790,744	0.025937	76,864	1,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,009,974	0.000000	79,128	0	92.00
200.00		Total (lines 50-199)	1,113,296	54,065,179		6,008,513	73,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,698,292	0.000000	0.000000	171,375	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	13,344,820	0.000000	0.000000	938,635	54.00
60.00	06000	LABORATORY	0	11,445,139	0.000000	0.000000	1,389,617	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,365,939	0.000000	0.000000	470,873	65.00
66.00	06600	PHYSICAL THERAPY	0	2,647,393	0.000000	0.000000	204,099	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,256,439	0.000000	0.000000	191,254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,088,630	0.000000	0.000000	1,170,114	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	155,569	0.000000	0.000000	4,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,998,252	0.000000	0.000000	1,312,316	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,120,736	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	956,134	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	187,118	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	2,790,744	0.000000	0.000000	76,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,009,974	0.000000	0.000000	79,128	92.00
200.00		Total (lines 50-199)	0	54,065,179			6,008,513	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.420780	0	1,054,552	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	0	5,864,916	0	0	54.00
60.00	06000	LABORATORY	0.247589	0	4,782,584	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	0	696,250	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	0	668,051	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	0	475,541	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	0	1,140,102	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	0	145,393	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	0	2,278,175	607	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.561228	0	956,134	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	11,919	0	0	90.01
91.00	09100	EMERGENCY	0.578346	0	916,833	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	0	484,552	0	0	92.00
200.00		Subtotal (see instructions)		0	19,475,002	607	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	19,475,002	607	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	443,734	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	908,698	0		54.00
60.00	06000	LABORATORY	1,184,115	0		60.00
65.00	06500	RESPIRATORY THERAPY	107,607	0		65.00
66.00	06600	PHYSICAL THERAPY	275,498	0		66.00
69.00	06900	ELECTROCARDIOLOGY	28,353	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,369	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	53,415	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	583,703	156		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	536,609	0		90.00
90.01	09001	WOUND CARE	7,359	0		90.01
91.00	09100	EMERGENCY	530,247	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	422,602	0		92.00
200.00		Subtotal (see instructions)	5,302,309	156		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,302,309	156		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 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	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 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	0	3,698,292	0.000000	0.000000	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	13,344,820	0.000000	0.000000	22,269	54.00
60.00	06000	LABORATORY	0	11,445,139	0.000000	0.000000	54,667	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,365,939	0.000000	0.000000	89,233	65.00
66.00	06600	PHYSICAL THERAPY	0	2,647,393	0.000000	0.000000	652,046	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,256,439	0.000000	0.000000	3,317	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,088,630	0.000000	0.000000	258,248	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	155,569	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,998,252	0.000000	0.000000	36,723	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,120,736	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	956,134	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	187,118	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	2,790,744	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,009,974	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	54,065,179			1,116,503	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/26/2013 11:06 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.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.420780	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	0	0	0	0	54.00
60.00	06000	LABORATORY	0.247589	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	0	0	199	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.561228	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.578346	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	199	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	199	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141311 | Component CCN: 145552 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	51		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	51		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.420780	0	0	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	0	0	0	0	54.00
60.00	06000	LABORATORY	0.247589	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.340602				0	88.00
90.00	09000	CLINIC	0.561228	0	0	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.578346	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,765	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)	2,666	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)	2,024	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,017,639	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)	3,017,639	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)	3,017,639	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)	801.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,622,236	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,622,236	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	424,746	291	1,459.61	188	274,407	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,407,368	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,304,011	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,099	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	801.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	880,849	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 11:06 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)	6,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,788	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)	6,788	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)	1,494	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,913,058	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)	1,913,058	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)	1,913,058	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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1

Component CCN: 145552 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Skilled Nursing Facility | 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)						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)	1,913,058	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	281.83	71.00
72.00	Program routine service cost (line 9 x line 71)	421,054	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)	421,054	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)	421,054	83.00
84.00	Program inpatient ancillary services (see instructions)	359,197	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)	780,251	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: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1

Component CCN: 145552 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,765	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)	2,666	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)	201	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,017,639	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)	3,017,639	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)	3,017,639	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)	801.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	161,102	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)	161,102	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	424,746	291	1,459.61	28	40,869	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	201,971	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,099	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	801.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	880,849	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,902,560		30.00
31.00	03100	INTENSIVE CARE UNIT		291,400		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.420780	171,375	72,111	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	938,635	145,430	54.00
60.00	06000	LABORATORY	0.247589	1,389,617	344,054	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	470,873	72,774	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	204,099	84,169	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	191,254	11,403	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	1,170,114	226,170	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	4,238	1,557	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	1,312,316	336,235	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.561228	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	0	90.01
91.00	09100	EMERGENCY	0.578346	76,864	44,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	79,128	69,011	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,008,513	1,407,368	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)		6,008,513		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3

Component CCN: 145552 | Date/Time Prepared: 11/26/2013 11:06 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	0.420780	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	22,269	3,450	54.00
60.00	06000	LABORATORY	0.247589	54,667	13,535	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	89,233	13,791	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	652,046	268,898	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	3,317	198	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	258,248	49,916	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	36,723	9,409	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.561228	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	0	90.01
91.00	09100	EMERGENCY	0.578346	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,116,503	359,197	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,116,503		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/26/2013 11:06 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.420780	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.154938	0	0	54.00
60.00	06000	LABORATORY	0.247589	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.154552	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.412391	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.059622	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.193289	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.367387	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.256215	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.340602	0	0	88.00
90.00	09000	CLINIC	0.561228	0	0	90.00
90.01	09001	WOUND CARE	0.617434	0	0	90.01
91.00	09100	EMERGENCY	0.578346	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.872150	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 11:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,302,465	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,302,465	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,355,490	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)	89,739	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,930,186	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)	2,335,565	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)	2,335,565	30.00
31.00	Primary payer payments	919	31.00
32.00	Subtotal (line 30 minus line 31)	2,334,646	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)	750,932	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	750,932	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	692,384	36.00
37.00	Subtotal (see instructions)	3,085,578	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,085,578	40.00
40.01	Sequestration adjustment (see instructions)	15,428	40.01
41.00	Interim payments	3,470,998	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-400,848	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	119,373	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 11:06 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	51	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	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	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	51	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	199	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)	199	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)	199	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	148	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)	51	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)	0	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)	51	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)	51	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	51	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)	51	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)	51	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
41.00	Interim payments	56	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-5	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/26/2013 11:06 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,076,160		3,470,998	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)		3,076,160		3,470,998	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		207,179		385,420	6.02
7.00	Total Medicare program liability (see instructions)		2,868,981		3,085,578	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: 141311 Component CCN: 145552	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part I Date/Time Prepared: 11/26/2013 11:06 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		528,505		56	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)		528,505		56	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		2,832		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		5	6.02
7.00	Total Medicare program liability (see instructions)		531,337		51	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141311	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/26/2013 11:06 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	842	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,212	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,957	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	60,421,954	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	2,550,666	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	194,329	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	190,656	8.00
9.00	Sequestration adjustment amount (see instructions)	3,813	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	186,843	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	186,653	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	190	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/26/2013 11:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	3,304,011	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	3,304,011	4.00
5.00	Primary payer payments	6,816	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,330,235	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,330,235	19.00
20.00	Deductibles (exclude professional component)	561,066	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,769,169	22.00
23.00	Coinsurance	2,960	23.00
24.00	Subtotal (line 22 minus line 23)	2,766,209	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	102,772	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	102,772	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	91,612	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,868,981	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,868,981	30.00
30.01	Sequestration adjustment (see instructions)	14,345	30.01
31.00	Interim payments	3,076,160	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	-221,524	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	74,372	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 11/26/2013 11:06 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)	604,708	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	604,708	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	1,227	6.00
7.00	Coinsurance	72,144	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)	531,337	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	531,337	15.00
15.01	Sequestration adjustment (see instructions)	2,657	15.01
16.00	Interim payments	528,505	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	175	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 11/26/2013 11:06 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	953,229	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	8,612,536	0	0	0	4.00
5.00	Other receivable	434,304	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,651,164	0	0	0	6.00
7.00	Inventory	330,331	0	0	0	7.00
8.00	Prepaid expenses	123,718	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)	5,802,954	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	34,372,432	0	0	0	15.00
16.00	Accumulated depreciation	-18,665,359	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,707,073	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,408	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,779,563	0	0	0	33.00
34.00	Other assets	939,687	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,726,658	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,236,685	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,355,375	0	0	0	37.00
38.00	Salaries, wages, and fees payable	286,200	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	802,360	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	0	0	0	0	43.00
44.00	Other current liabilities	655,264	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,099,199	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,833,245	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,833,245	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	10,932,444	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,304,241				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)	13,304,241	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,236,685	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 11/26/2013 11:06 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		12,823,821		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		695,894				2.00
3.00	Total (sum of line 1 and line 2)		13,519,715		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)		13,519,715		0		11.00
12.00	Deductions (debit adjustments) (specify)	215,474		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)		215,474		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,304,241		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/26/2013 11:06 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,485,543		5,485,543	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	904,450		904,450	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,389,993		6,389,993	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	432,550		432,550	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)	432,550		432,550	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,822,543		6,822,543	17.00
18.00	Ancillary services	8,746,529	40,231,807	48,978,336	18.00
19.00	Outpatient services	0	956,134	956,134	19.00
20.00	RURAL HEALTH CLINIC	0	3,120,736	3,120,736	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		544,206	544,206	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				26.00
27.00	PRO FEES	322,630	5,475,063	5,797,693	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,891,702	50,327,946	66,219,648	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,756,996		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	WAYFAIR	133,156			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)		133,156		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,623,840		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 11/26/2013 11:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,219,648	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,075,953	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,143,695	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,623,840	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-480,145	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and 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 REVENUE	813,852	24.00
24.01	NON OPERATING REVENUE	362,187	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	1,176,039	25.00
26.00	Total (line 5 plus line 25)	695,894	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	695,894	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H | Date/Time Prepared: 11/26/2013 11:06 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	28,581	0	36,064	1,286	25,243	91,174	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	129,939	0	0	0	0	129,939	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	DIRECTOR	77,057	0	0	0	0	77,057	23.00
24.00	Total (sum of lines 1-23)	235,577	0	36,064	1,286	25,243	298,170	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	91,174	0	91,174			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	129,939	0	129,939			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	DIRECTOR	0	77,057	0	77,057			23.00
24.00	Total (sum of lines 1-23)	0	298,170	0	298,170			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: 141311 HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-1 Part I Date/Time Prepared: 11/26/2013 11:06 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	91,174	0	0	0	0	91,174	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	129,939	0	0	0	0	129,939	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	DIRECTOR	77,057	0	0	0	0	77,057	23.00
24.00	Total (sum of lines 1-23)	298,170	0	0	0	0	298,170	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	91,174		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	57,233	187,172	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	0	0	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	DIRECTOR	33,941	110,998	23.00
24.00	Total (sum of lines 1-23)		298,170	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141311 HHA CCN: 147612

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

Worksheet H-1 Part II Date/Time Prepared: 11/26/2013 11:06 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	-91,174	206,996	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	129,939	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	DIRECTOR	0	0	0	0	0	77,057	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-91,174	206,996	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		91,174	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.440463	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311 HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2013 11:06 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	27,232	6,336	55,632	89,200	12,123	1.00
2.00	Skilled Nursing Care	187,172	0	0	0	187,172	25,438	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	DIRECTOR	110,998	0	0	0	110,998	15,085	19.00
20.00	Total (sum of lines 1-19) (2)	298,170	27,232	6,336	55,632	387,370	52,646	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	21,459	18,445	0	17,604	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	DIRECTOR	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	21,459	18,445	0	17,604	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: 141311 HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I Date/Time Prepared: 11/26/2013 11:06 am

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	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		13.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	158,831	0	158,831	1.00
2.00	Skilled Nursing Care	0	0	0	212,610	0	212,610	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	DIRECTOR	0	0	0	126,083	0	126,083	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	497,524	0	497,524	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	99,704	312,314					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	DIRECTOR	59,127	185,210					19.00
20.00	Total (sum of lines 1-19) (2)	158,831	497,524					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.	0.468953						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: 141311 | HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part II | Date/Time Prepared: 11/26/2013 11:06 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,920	1,920	235,577	0	89,200	1,920	1.00
2.00	Skilled Nursing Care	0	0	0	0	187,172	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	DIRECTOR	0	0	0	0	110,998	0	19.00
20.00	Total (sum of lines 1-19)	1,920	1,920	235,577		387,370	1,920	20.00
21.00	Total cost to be allocated	27,232	6,336	55,632		52,646	21,459	21.00
22.00	Unit cost multiplier	14.183333	3.300000	0.236152		0.135906	11.176562	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,920	0	1,920	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	DIRECTOR	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00	Total cost to be allocated	18,445	0	17,604	0	0	0	21.00
22.00	Unit cost multiplier	9.606771	0.000000	9.168750	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part II | Date/Time Prepared: 11/26/2013 11:06 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 11/26/2013 11:06 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	312,314		312,314	2,233	139.86	1.00
2.00	Physical Therapy	3.00	0	0	0	980	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	252	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	80	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		312,314	0	312,314	3,545		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		14999	766	971			8.00
9.00	Physical Therapy		14999	439	377			9.00
10.00	Occupational Therapy		14999	108	97			10.00
11.00	Speech Pathology		14999	60	11			11.00
12.00	Medical Social Services		14999	0	0			12.00
13.00	Home Health Aide		14999	0	0			13.00
14.00	Total (sum of lines 8-13)			1,373	1,456			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	766	971		107,133	135,804		1.00
2.00	Physical Therapy	439	377		0	0		2.00
3.00	Occupational Therapy	108	97		0	0		3.00
4.00	Speech Pathology	60	11		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	1,373	1,456		107,133	135,804		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141311 HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I Date/Time Prepared: 11/26/2013 11:06 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	242,937	1.00
2.00	Physical Therapy	0	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	242,937	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141311 | HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part II | Date/Time Prepared: 11/26/2013 11:06 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	0.412391	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	0.193289	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.256215	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/26/2013 11:06 am

HHA CCN: 147612 | Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	181,752	204,813	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	11,818	10,766	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	4,786	1,391	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,183	181	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	1,379	3,950	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)	200,918	221,101	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	200,918	221,101	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	200,918	221,101	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)	200,918	221,101	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-421	-793	30.00
31.00	Subtotal (line 29 plus/minus line 30)	200,497	220,308	31.00
31.01	Sequestration adjustment (see instructions)	807	947	31.01
32.00	Interim payments (see instructions)	200,110	220,153	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	-420	-792	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: 141311 HHA CCN: 147612 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-5 | Date/Time Prepared: 11/26/2013 11:06 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		200,110		220,153	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)		200,110		220,153	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		387		155	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		200,497		220,308	7.00

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

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

Provider CCN: 141311 Component CCN: 148500 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/26/2013 11:06 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	1,197,553	0	1,197,553	0	1,197,553	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	340,709	0	340,709	0	340,709	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,538,262	0	1,538,262	0	1,538,262	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,538,262	0	1,538,262	0	1,538,262	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	0	0	0	0	29.00
30.00	Administrative Costs	636,498	273,232	909,730	-2,166	907,564	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	636,498	273,232	909,730	-2,166	907,564	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,174,760	273,232	2,447,992	-2,166	2,445,826	32.00

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

Provider CCN: 141311 | Component CCN: 148500 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/26/2013 11:06 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	1,197,553		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	340,709		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	1,538,262		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,538,262		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	907,564		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	907,564		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,445,826		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141311 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-2

Component CCN: 148500 | Date/Time Prepared: 11/26/2013 11:06 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	3.51	12,078	4,200	14,742		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.62	8,823	2,100	5,502		3.00
4.00	Subtotal (sum of lines 1-3)	6.13	20,901		20,244	20,901	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)	6.13	20,901			20,901	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)					1,538,262	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)					1,538,262	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)					907,564	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,737,840	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,645,404	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					2,645,404	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,645,404	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,183,666	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141311 | Component CCN: 148500 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-3 | Date/Time Prepared: 11/26/2013 11:06 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)		4,183,666	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,183,666	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		20,901	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)		20,901	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		200.17	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)	200.17	200.17	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	7,203	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,441,825	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) *		1,441,825	16.00
16.01	Total program charges (see instructions)(from contractor's records)		725,098	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,389	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,763	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.)		1,086,602	16.04
16.05	Total program cost (see instructions)		1,089,365	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		80,810	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		128,580	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,089,365	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,089,365	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		1,089,365	26.00
26.01	Sequestration adjustment (see instructions)		5,447	26.01
27.00	Interim payments		1,018,348	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		65,570	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		25,698	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141311 Component CCN: 148500 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-5 | Date/Time Prepared: 11/26/2013 11:06 am

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		941,748	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		01/14/2013	76,600	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)		76,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,018,348	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		71,017	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,089,365	7.00

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