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: 141319

Period:
From 06/01/2012
To 05/31/2013

Worksheet S
Parts I-III
Date/Time Prepared:
8/20/2013 1:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/20/2013 Time: 1:02 pm
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 HAMMOND-HENRY HOSPITAL (141319) for the cost reporting period beginning 06/01/2012 and ending 05/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	37,776	284,476	33,613	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	-69,441	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	-57		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	-31,666	284,419	33,613	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	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	HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	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	HAMMOND-HENRY SWING BED	14Z319	19340		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HAMMOND-HENRY SKILLED NURSING	145464	19340		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HAMMOND-HENRY HOME HEALTH SERVICES	147450	19340		06/05/1986	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									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2012	05/31/2013	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days 1.00	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days 3.00	Out-of State Medicaid eligible unpaid 4.00	Medicaid HMO days 5.00	Other Medicaid days 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 1.00	Date of Geogr 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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141319	Period: From 06/01/2012 To 05/31/2013	Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	417,149	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)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	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
161.10	CORF		N	N	N	161.10

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							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)						1,398,529	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/20/2013 1:02 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	07/15/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/20/2013 1:02 pm

		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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/20/2013 1:02 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	07/15/2013			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 8/20/2013 1:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	83,712.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	83,712.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	83,712.00	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	37	13,505		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			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
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		62				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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,876	417	3,488			1.00
2.00	HMO	164	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	612	0	674			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	41			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,488	417	4,203			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		214	435			13.00
14.00	Total (see instructions)	2,488	631	4,638	0.00	214.81	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	1,340	0	13,052	0.00	25.69	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	8,804	103	10,918	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	240.50	27.00
28.00	Observation Bed Days		0	646			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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	601	209	1,249	1.00
2.00	HMO			46			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	601	209	1,249	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						20.00
21.00	OTHER LONG TERM CARE	0.00				0	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
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141319 | Component CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-4 | Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

						1.00	
0.00	County				HENRY		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	14,483	0	0	14,483	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	273.00	0.00	0.00	237.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.12	0.00	1.12	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	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			6.96	0.00	6.96	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.			5			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			19340			20.00
20.01				37900			20.01
20.02				99914			20.02
20.03				50208			20.03
20.04				49740			20.04
		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	3,828	271	88	71	4,258	21.00
22.00	Skilled Nursing Visit Charges	515,658	36,639	11,882	9,599	573,778	22.00
23.00	Physical Therapy Visits	1,539	50	1	15	1,605	23.00
24.00	Physical Therapy Visit Charges	261,081	8,493	170	2,548	272,292	24.00
25.00	Occupational Therapy Visits	927	83	6	40	1,056	25.00
26.00	Occupational Therapy Visit Charges	157,304	14,098	1,019	6,794	179,215	26.00
27.00	Speech Pathology Visits	125	17	0	0	142	27.00
28.00	Speech Pathology Visit Charges	21,231	2,887	0	0	24,118	28.00
29.00	Medical Social Service Visits	25	1	1	2	29	29.00
30.00	Medical Social Service Visit Charges	5,144	208	208	416	5,976	30.00
31.00	Home Health Aide Visits	1,498	152	6	58	1,714	31.00
32.00	Home Health Aide Visit Charges	108,657	11,066	437	4,222	124,382	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,942	574	102	186	8,804	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)	1,069,075	73,391	13,716	23,579	1,179,761	35.00
36.00	Total Number of Episodes (standard/non outlier)	379		35	10	424	36.00
37.00	Total Number of Outlier Episodes		10		1	11	37.00
38.00	Total Non-Routine Medical Supply Charges	19	0	0	0	19	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-7 | Date/Time Prepared: 8/20/2013 1:02 pm

		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.	Y	05/21/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	16	0	16	5.00
6.00		RVL	9	0	9	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	30	0	30	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	21	0	21	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	103	0	103	12.00
13.00		RUB	79	0	79	13.00
14.00		RUA	91	0	91	14.00
15.00		RVC	91	0	91	15.00
16.00		RVB	103	0	103	16.00
17.00		RVA	369	0	369	17.00
18.00		RHC	21	0	21	18.00
19.00		RHB	72	0	72	19.00
20.00		RHA	68	0	68	20.00
21.00		RMC	59	0	59	21.00
22.00		RMB	3	0	3	22.00
23.00		RMA	20	0	20	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	27	0	27	28.00
29.00		HE2	14	0	14	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	15	0	15	32.00
33.00		HC2	35	0	35	33.00
34.00		HC1	1	0	1	34.00
35.00		HB2	14	0	14	35.00
36.00		HB1	9	0	9	36.00
37.00		LE2	9	0	9	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	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	3	0	3	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	2	0	2	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	56	0	56	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-7 | Date/Time Prepared: 8/20/2013 1:02 pm

		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	0	0	0	78.00
199.00		AAA	0	419	419	199.00
200.00	TOTAL		1,340	419	1,759	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).	99914	99914	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	771,695	33.02	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	1,540	0.07	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,337,322			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet S-10 | Date/Time Prepared: 8/20/2013 1:02 pm

		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)	0.488710	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,446,424	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	725,831	5.00
6.00	Medicaid charges	4,371,758	6.00
7.00	Medicaid cost (line 1 times line 6)	2,136,522	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	379,105	145,125	524,230	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	185,272	70,924	256,196	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	185,272	70,924	256,196	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)	1,645,287	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	273,198	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,372,089	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	670,554	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	926,750	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	926,750	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A | Date/Time Prepared: 8/20/2013 1:02 pm

		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		2,081,256	2,081,256	964,954	3,046,210	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,445,100	1,445,100	15,337	1,460,437	2.00
4.00	00400	EMPLOYEE BENEFITS	57,973	3,918,805	3,976,778	0	3,976,778	4.00
5.01	00520	DATA PROCESSING	369,287	297,510	666,797	0	666,797	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	109,084	6,088	115,172	0	115,172	5.02
5.03	00540	ADMITTING	168,463	15,021	183,484	0	183,484	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	249,053	187,347	436,400	-74,319	362,081	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	593,959	1,755,062	2,349,021	11,833	2,360,854	5.05
7.00	00700	OPERATION OF PLANT	186,793	989,991	1,176,784	0	1,176,784	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,374	112,349	142,723	0	142,723	8.00
9.00	00900	HOUSEKEEPING	329,110	103,286	432,396	0	432,396	9.00
10.00	01000	DIETARY	453,499	408,620	862,119	0	862,119	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,221	1,606	123,827	0	123,827	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,049	33,049	0	33,049	14.00
15.00	01500	PHARMACY	168,992	187,086	356,078	0	356,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	283,416	60,521	343,937	0	343,937	16.00
17.00	01700	SOCIAL SERVICE	180,250	1,258	181,508	0	181,508	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,923,511	215,114	2,138,625	-206,738	1,931,887	30.00
43.00	04300	NURSERY	0	0	0	169,109	169,109	43.00
44.00	04400	SKILLED NURSING FACILITY	810,744	69,826	880,570	0	880,570	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,275,608	2,229,380	3,504,988	-882,858	2,622,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	37,629	37,629	52.00
53.00	05300	ANESTHESIOLOGY	684,762	115,737	800,499	-115,737	684,762	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	665,291	1,262,222	1,927,513	41,753	1,969,266	54.00
60.00	06000	LABORATORY	568,026	780,704	1,348,730	0	1,348,730	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	137,562	137,562	0	137,562	62.00
64.00	06400	INTRAVENOUS THERAPY	32,820	7,584	40,404	0	40,404	64.00
66.00	06600	PHYSICAL THERAPY	1,025,551	101,109	1,126,660	0	1,126,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	314,602	22,101	336,703	0	336,703	67.00
68.00	06800	SPEECH PATHOLOGY	70,765	4,986	75,751	0	75,751	68.00
69.00	06900	ELECTROCARDIOLOGY	285,905	190,766	476,671	0	476,671	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	998,595	998,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	618,543	618,543	0	618,543	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	66,895	56,429	123,324	0	123,324	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	588,403	508,299	1,096,702	38,583	1,135,285	90.00
90.01	09001	OB CLINIC	394,197	91,596	485,793	0	485,793	90.01
91.00	09100	EMERGENCY	517,806	1,432,082	1,949,888	0	1,949,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	463,627	111,472	575,099	0	575,099	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,013,700	1,013,700	-1,013,700	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,990,987	20,573,167	33,564,154	-15,559	33,548,595	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	15,559	15,559	192.00
192.02	19201	ORTHO CLINIC	19,711	107,538	127,249	0	127,249	192.02
192.03	19202	LEASED SPACE	6,711	70,779	77,490	0	77,490	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	19,279	75,385	94,664	0	94,664	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	13,036,688	20,826,869	33,863,557	0	33,863,557	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-161,093	2,885,117		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-494,245	966,192		2.00
4.00	00400	EMPLOYEE BENEFITS	-296,613	3,680,165		4.00
5.01	00520	DATA PROCESSING	0	666,797		5.01
5.02	00530	PURCHASING RECEIVING AND STORES	-6,212	108,960		5.02
5.03	00540	ADMITTING	0	183,484		5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	362,081		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-187,006	2,173,848		5.05
7.00	00700	OPERATION OF PLANT	0	1,176,784		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,723		8.00
9.00	00900	HOUSEKEEPING	0	432,396		9.00
10.00	01000	DIETARY	-170,855	691,264		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	123,827		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,049		14.00
15.00	01500	PHARMACY	0	356,078		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,170	342,767		16.00
17.00	01700	SOCIAL SERVICE	0	181,508		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,931,887		30.00
43.00	04300	NURSERY	0	169,109		43.00
44.00	04400	SKILLED NURSING FACILITY	-132	880,438		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,000	2,621,130		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,629		52.00
53.00	05300	ANESTHESIOLOGY	-684,762	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-41,753	1,927,513		54.00
60.00	06000	LABORATORY	0	1,348,730		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	137,562		62.00
64.00	06400	INTRAVENOUS THERAPY	0	40,404		64.00
66.00	06600	PHYSICAL THERAPY	-126,192	1,000,468		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	336,703		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,751		68.00
69.00	06900	ELECTROCARDIOLOGY	-19,129	457,542		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	998,595		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	618,543		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	123,324		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-607,691	527,594		90.00
90.01	09001	OB CLINIC	-302,994	182,799		90.01
91.00	09100	EMERGENCY	-508,237	1,441,651		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	-8,880	566,219		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,617,964	29,930,631		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,559		192.00
192.02	19201	ORTHO CLINIC	0	127,249		192.02
192.03	19202	LEASED SPACE	0	77,490		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	94,664		194.04
194.05	07954	COLONA CLINIC	0	0		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-3,617,964	30,245,593		200.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 1:02 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	38,583		1.00
	TOTALS		0	38,583		
	B - FMA BUILDING DEPRECIATION					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,559		1.00
	TOTALS		0	15,559		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	960,114		1.00
	TOTALS		0	960,114		
	D - CAPITAL LEASE INTEREST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	11,833		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,753		2.00
	TOTALS		0	53,586		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58,982		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,337		2.00
	TOTALS		0	74,319		
	F - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	37,629	0		1.00
	TOTALS		37,629	0		
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE					
1.00	OPERATING ROOM	50.00	0	115,737		1.00
	TOTALS		0	115,737		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	998,595		1.00
	TOTALS		0	998,595		
	I - NURSERY RECLASS					
1.00	NURSERY	43.00	168,460	649		1.00
	TOTALS		168,460	649		
500.00	Grand Total: Increases		206,089	2,257,142		500.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/20/2013 1:02 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - COLONA CLINIC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,583	9		1.00
	TOTALS		0	38,583			
	B - FMA BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,559	9		1.00
	TOTALS		0	15,559			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	960,114	11		1.00
	TOTALS		0	960,114			
	D - CAPITAL LEASE INTEREST						
1.00	INTEREST EXPENSE	113.00	0	53,586	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	53,586			
	E - OTHER CAPITAL COSTS						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	74,319	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	74,319			
	F - DELIVERY AND LABOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	37,629	0	0		1.00
	TOTALS		37,629	0			
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	115,737	0		1.00
	TOTALS		0	115,737			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	998,595	0		1.00
	TOTALS		0	998,595			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	168,460	649	0		1.00
	TOTALS		168,460	649			
500.00	Grand Total: Decreases		206,089	2,257,142			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,210,071	59,448	0	59,448	0	1.00
2.00	Land Improvements	1,008,655	25,074	228,169	253,243	12,544	2.00
3.00	Buildings and Fixtures	39,587,306	250,608	6,240,851	6,491,459	1,561,025	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,368,454	708,038	444,720	1,152,758	289,855	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,174,486	1,043,168	6,913,740	7,956,908	1,863,424	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,174,486	1,043,168	6,913,740	7,956,908	1,863,424	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,269,519	0	1.00
2.00	Land Improvements	1,249,354	0	2.00
3.00	Buildings and Fixtures	44,517,740	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,231,357	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,267,970	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	59,267,970	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 8/20/2013 1:02 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,081,256	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,445,100	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,526,356	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	2,081,256		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,445,100		2.00
3.00	Total (sum of lines 1-2)	0	3,526,356		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-7 Part III Date/Time Prepared: 8/20/2013 1:02 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	47,036,613	0	47,036,613	0.793626	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,231,357	0	12,231,357	0.206374	0	2.00
3.00	Total (sum of lines 1-2)	59,267,970	0	59,267,970	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,027,114	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	950,855	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,977,969	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	799,021	58,982	0	0	2,885,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,337	0	0	966,192	2.00
3.00	Total (sum of lines 1-2)	799,021	74,319	0	0	3,851,309	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/20/2013 1:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - 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)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,439,051			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-490,326	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INVESTMENT INCOME - CAP REL COSTS-BL	B	-37,738	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	CAFETERIA-EMPLOYEES AND GUESTS	B	-152,011	DIETARY	10.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/20/2013 1:02 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-1,170	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	VENDING MACHINES	B	-1,307	DIETARY	10.00	0	33.03
33.04	DIETARY RECEIPTS - OTHER	B	-17,537	DIETARY	10.00	0	33.04
33.05	SUPPLIES REBATES	B	-5,558	PURCHASING RECEIVING AND STORES	5.02	0	33.05
33.06	ATHLETIC TRAINING REVENUE	B	-19,393	PHYSICAL THERAPY	66.00	0	33.06
33.07	A/P REVENUE	B	-654	PURCHASING RECEIVING AND STORES	5.02	0	33.07
33.08	PHYSICAL THERAPY TO SUMMIT	B	-74,538	PHYSICAL THERAPY	66.00	0	33.08
33.09	PT OUTREACH REVENUE	A	-32,261	PHYSICAL THERAPY	66.00	0	33.09
33.10	LIFELINE REVENUE	B	-8,880	HOME HEALTH AGENCY	101.00	0	33.10
33.11	FOUNDATION EXPENSES	B	-93,240	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	ADVERTISING EXPENSE	B	-77,961	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.12
33.13	CRNA EXPENSE	B	-684,762	ANESTHESIOLOGY	53.00	0	33.13
33.14	CRNA FRINGES	B	-159,308	EMPLOYEE BENEFITS	4.00	0	33.14
33.15	LTC OTHER REVENUE	B	-132	SKILLED NURSING FACILITY	44.00	0	33.15
33.16	PHYSICIAN RECRUITMENT EXPENSE	B	-53	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.16
33.17			0		0.00	0	33.17
33.18	CABLE TV	A	-3,919	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19	TELEPHONE SERVICES	A	-3,919	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.19
33.20			0		0.00	0	33.20
33.21			0		0.00	0	33.21
33.22			0		0.00	0	33.22
33.23	UNNECESARY BORROWING	B	-123,355	CAP REL COSTS-BLDG & FIXT	1.00	11	33.23
33.24			0		0.00	0	33.24
33.25	UNNECESSARY BORROWING - CAP LEASE	A	-11,833	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.25
33.26	UNNECESSARY BORROWING - CAP LEASE	A	-41,753	RADIOLOGY-DIAGNOSTIC	54.00	0	33.26
33.27	PHYSICIAN BENEFIT OFFSET	A	-137,305	EMPLOYEE BENEFITS	4.00	0	33.27
33.28			0		0.00	0	33.28
33.29			0		0.00	0	33.29
33.30			0		0.00	0	33.30
34.00			0		0.00	0	34.00
35.00			0		0.00	0	35.00
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,617,964				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 8/20/2013 1:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	50,200	0	50,200	0	0	1.00
2.00	91.00	EMERGENCY	1,311,305	508,237	803,068	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	19,129	19,129	0	0	0	3.00
4.00	90.00	CLINIC	287,192	287,192	0	0	0	4.00
5.00	90.00	CLINIC	320,499	320,499	0	0	0	5.00
6.00	90.01	OB CLINIC	302,994	302,994	0	0	0	6.00
7.00	50.00	OPERATING ROOM	1,000	1,000	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			2,292,319	1,439,051	853,268		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	OB CLINIC	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	508,237		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	19,129		3.00
4.00	90.00	CLINIC	0	0	0	287,192		4.00
5.00	90.00	CLINIC	0	0	0	320,499		5.00
6.00	90.01	OB CLINIC	0	0	0	302,994		6.00
7.00	50.00	OPERATING ROOM	0	0	0	1,000		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	1,439,051		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 1:02 pm

		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	DATA PROCESSING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,885,117	2,885,117				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	966,192		966,192			2.00
4.00	00400	EMPLOYEE BENEFITS	3,680,165	7,755	0	3,687,920		4.00
5.01	00520	DATA PROCESSING	666,797	45,424	117,529	116,364	946,114	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	108,960	69,896	0	34,373	14,724	5.02
5.03	00540	ADMITTING	183,484	38,954	14,834	53,084	26,340	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	362,081	16,717	1,052	78,478	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,173,848	247,951	36,451	187,159	85,401	5.05
7.00	00700	OPERATION OF PLANT	1,176,784	249,395	22,344	58,859	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	142,723	12,998	1,397	9,571	0	8.00
9.00	00900	HOUSEKEEPING	432,396	31,555	0	103,704	2,618	9.00
10.00	01000	DIETARY	691,264	101,234	4,100	142,900	5,890	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,636	11.00
13.00	01300	NURSING ADMINISTRATION	123,827	10,189	359	38,512	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,049	0	0	0	0	14.00
15.00	01500	PHARMACY	356,078	22,534	3,551	53,250	55,625	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	342,767	33,039	8,822	89,306	56,443	16.00
17.00	01700	SOCIAL SERVICE	181,508	9,615	0	56,798	1,963	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,931,887	288,706	36,336	541,173	162,785	30.00
43.00	04300	NURSERY	169,109	0	6,731	53,083	0	43.00
44.00	04400	SKILLED NURSING FACILITY	880,438	327,284	33,568	255,469	23,722	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,621,130	308,470	174,165	401,950	42,864	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,629	19,032	0	11,857	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,927,513	155,422	324,333	209,637	40,083	54.00
60.00	06000	LABORATORY	1,348,730	51,616	13,651	178,988	31,412	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	137,562	1,602	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	40,404	9,694	0	10,342	0	64.00
66.00	06600	PHYSICAL THERAPY	1,000,468	167,549	25,998	323,156	24,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,703	8,626	0	99,133	23,232	67.00
68.00	06800	SPEECH PATHOLOGY	75,751	0	0	22,298	5,235	68.00
69.00	06900	ELECTROCARDIOLOGY	457,542	40,280	41,946	90,090	11,943	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	998,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	618,543	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	123,324	12,523	3,731	21,079	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	527,594	0	50,500	94,913	243,111	90.00
90.01	09001	OB CLINIC	182,799	74,209	7,919	28,739	0	90.01
91.00	09100	EMERGENCY	1,441,651	75,831	19,176	163,163	64,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	566,219	21,525	250	146,091	21,923	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,930,631	2,459,625	948,743	3,673,519	946,114	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,162	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,559	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	127,249	0	9,406	6,211	0	192.02
192.03	19202	LEASED SPACE	77,490	387,764	8,043	2,115	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	8,349	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	11,217	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	94,664	0	0	6,075	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,245,593	2,885,117	966,192	3,687,920	946,114	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		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						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES	227,953					5.02
5.03	00540	ADMITTING	349	317,045				5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	465	0	458,793			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,487	0	0	2,733,297	2,733,297	5.05
7.00	00700	OPERATION OF PLANT	4,739	0	0	1,512,121	150,226	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	158	0	0	166,847	16,576	8.00
9.00	00900	HOUSEKEEPING	4,241	0	0	574,514	57,077	9.00
10.00	01000	DIETARY	2,613	0	0	948,001	94,182	10.00
11.00	01100	CAFETERIA	0	0	0	1,636	163	11.00
13.00	01300	NURSING ADMINISTRATION	11	0	0	172,898	17,177	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,379	0	0	34,428	3,420	14.00
15.00	01500	PHARMACY	413	0	0	491,451	48,825	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249	0	0	530,626	52,717	16.00
17.00	01700	SOCIAL SERVICE	3	0	0	249,887	24,826	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,650	18,376	25,286	3,016,199	299,653	30.00
43.00	04300	NURSERY	38	1,630	2,243	232,834	23,132	43.00
44.00	04400	SKILLED NURSING FACILITY	2,490	11,916	16,396	1,551,283	154,117	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,647	62,940	86,607	3,767,773	374,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,014	2,771	73,303	7,283	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,528	64,334	88,514	2,823,364	280,496	54.00
60.00	06000	LABORATORY	28,002	35,347	48,639	1,736,385	172,506	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,336	1,839	142,339	14,141	62.00
64.00	06400	INTRAVENOUS THERAPY	487	16,601	22,844	100,372	9,972	64.00
66.00	06600	PHYSICAL THERAPY	1,507	20,298	27,930	1,591,774	158,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	205	6,637	9,133	483,669	48,052	67.00
68.00	06800	SPEECH PATHOLOGY	22	967	1,330	105,603	10,491	68.00
69.00	06900	ELECTROCARDIOLOGY	998	11,661	15,639	670,099	66,573	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,443	1,986	3,429	341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,164	9,199	12,659	1,084,617	107,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,850	16,306	646,699	64,248	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	276	3,227	4,441	168,601	16,750	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	6,035	0	2,532	924,685	91,866	90.00
90.01	09001	OB CLINIC	2,566	0	726	296,958	29,502	90.01
91.00	09100	EMERGENCY	6,508	28,981	23,834	1,823,440	181,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,228	0	6,252	764,488	75,950	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,458	308,757	417,907	29,423,620	2,651,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,162	1,804	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	15,559	1,546	192.00
192.02	19201	ORTHO CLINIC	298	0	0	143,164	14,223	192.02
192.03	19202	LEASED SPACE	65	0	0	475,477	47,238	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	8,349	829	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	29,481	29,481	2,929	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	11,217	1,114	194.02
194.03	07952	ANESTHESIA BILLNG	0	8,288	11,405	19,693	1,956	194.03
194.04	07953	SPECIALTY CLINIC	132	0	0	100,871	10,021	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	227,953	317,045	458,793	30,245,593	2,733,297	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part I Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,662,347					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,864	195,287				8.00
9.00	00900	HOUSEKEEPING	28,802	17,205	677,598			9.00
10.00	01000	DIETARY	92,401	1,128	40,107	1,175,819		10.00
11.00	01100	CAFETERIA	0	0	1,920	784,834	788,553	11.00
13.00	01300	NURSING ADMINISTRATION	9,300	0	0	0	5,326	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	20,568	0	2,267	0	12,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,156	0	4,848	0	44,688	16.00
17.00	01700	SOCIAL SERVICE	8,776	0	3,400	0	16,365	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	263,515	42,838	158,662	99,915	148,782	30.00
43.00	04300	NURSERY	0	0	3,306	0	12,782	43.00
44.00	04400	SKILLED NURSING FACILITY	298,726	61,341	141,728	291,070	121,718	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	281,554	28,530	99,543	0	116,053	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,371	0	0	0	5,181	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	141,861	13,349	8,185	0	56,889	54.00
60.00	06000	LABORATORY	47,112	0	11,963	0	60,569	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,463	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	8,848	0	0	0	1,549	64.00
66.00	06600	PHYSICAL THERAPY	152,930	12,940	30,033	0	86,713	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,873	0	9,130	0	23,433	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,987	68.00
69.00	06900	ELECTROCARDIOLOGY	36,765	0	12,215	0	22,562	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	11,430	1,378	8,374	0	6,052	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	67,734	0	0	0	0	90.01
91.00	09100	EMERGENCY	69,215	16,578	8,185	0	39,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	19,647	0	3,715	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,627,911	195,287	547,581	1,175,819	785,939	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,577	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	2,614	192.02
192.03	19202	LEASED SPACE	0	0	130,017	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	7,620	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	10,239	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,662,347	195,287	677,598	1,175,819	788,553	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part I Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	204,701					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,848				14.00
15.00	01500	PHARMACY	5,825	0	581,912			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	663,035		16.00
17.00	01700	SOCIAL SERVICE	7,346	0	0	0	310,600	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,792	0	0	37,314	73,466	30.00
43.00	04300	NURSERY	5,738	0	0	3,310	6,927	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	24,196	209,628	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,099	0	0	127,806	1,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,326	0	0	4,089	51	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	130,653	0	54.00
60.00	06000	LABORATORY	27,191	0	0	71,776	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,714	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	33,710	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	41,217	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	13,478	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,963	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	23,079	657	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,848	0	2,930	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	18,680	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	581,912	24,062	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	6,553	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	5,410	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	17,649	0	0	35,171	9,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	19,735	0	0	0	3,742	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	204,701	37,848	581,912	602,701	310,600	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	43,504	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	16,830	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	204,701	37,848	581,912	663,035	310,600	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00520	DATA PROCESSING					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00540	ADMITTING					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,207,136	0	4,207,136		30.00
43.00	04300	NURSERY	288,029	0	288,029		43.00
44.00	04400	SKILLED NURSING FACILITY	2,853,807	0	2,853,807		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,849,301	0	4,849,301		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,604	0	109,604		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,454,797	0	3,454,797		54.00
60.00	06000	LABORATORY	2,127,502	0	2,127,502		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	160,657	0	160,657		62.00
64.00	06400	INTRAVENOUS THERAPY	154,451	0	154,451		64.00
66.00	06600	PHYSICAL THERAPY	2,073,747	0	2,073,747		66.00
67.00	06700	OCCUPATIONAL THERAPY	585,635	0	585,635		67.00
68.00	06800	SPEECH PATHOLOGY	123,044	0	123,044		68.00
69.00	06900	ELECTROCARDIOLOGY	831,950	0	831,950		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,548	0	44,548		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,211,052	0	1,211,052		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,316,921	0	1,316,921		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	219,138	0	219,138		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	1,021,961	0	1,021,961		90.00
90.01	09001	OB CLINIC	394,194	0	394,194		90.01
91.00	09100	EMERGENCY	2,199,808	0	2,199,808		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	887,277	0	887,277		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,114,559	0	29,114,559		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,543	0	36,543		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,105	0	17,105		192.00
192.02	19201	ORTHO CLINIC	160,001	0	160,001		192.02
192.03	19202	LEASED SPACE	652,732	0	652,732		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	16,798	0	16,798		194.00
194.01	07950	PHYSICIAN BILLING COSTS	75,914	0	75,914		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	22,570	0	22,570		194.02
194.03	07952	ANESTHESIA BILLNG	38,479	0	38,479		194.03
194.04	07953	SPECIALTY CLINIC	110,892	0	110,892		194.04
194.05	07954	COLONA CLINIC	0	0	0		194.05
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)	30,245,593	0	30,245,593		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			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	0	7,755	0	7,755	7,755	4.00
5.01	00520	DATA PROCESSING	0	45,424	117,529	162,953	245	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	0	69,896	0	69,896	72	5.02
5.03	00540	ADMITTING	0	38,954	14,834	53,788	112	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	16,717	1,052	17,769	165	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	247,951	36,451	284,402	394	5.05
7.00	00700	OPERATION OF PLANT	0	249,395	22,344	271,739	124	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,998	1,397	14,395	20	8.00
9.00	00900	HOUSEKEEPING	0	31,555	0	31,555	218	9.00
10.00	01000	DIETARY	0	101,234	4,100	105,334	301	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,189	359	10,548	81	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	22,534	3,551	26,085	112	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,039	8,822	41,861	188	16.00
17.00	01700	SOCIAL SERVICE	0	9,615	0	9,615	120	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	288,706	36,336	325,042	1,132	30.00
43.00	04300	NURSERY	0	0	6,731	6,731	112	43.00
44.00	04400	SKILLED NURSING FACILITY	0	327,284	33,568	360,852	538	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	308,470	174,165	482,635	846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,032	0	19,032	25	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	155,422	324,333	479,755	441	54.00
60.00	06000	LABORATORY	0	51,616	13,651	65,267	377	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,602	0	1,602	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	9,694	0	9,694	22	64.00
66.00	06600	PHYSICAL THERAPY	0	167,549	25,998	193,547	680	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,626	0	8,626	209	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	47	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,280	41,946	82,226	190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	12,523	3,731	16,254	44	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	50,500	50,500	200	90.00
90.01	09001	OB CLINIC	0	74,209	7,919	82,128	60	90.01
91.00	09100	EMERGENCY	0	75,831	19,176	95,007	343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	21,525	250	21,775	307	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,459,625	948,743	3,408,368	7,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,162	0	18,162	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	9,406	9,406	13	192.02
192.03	19202	LEASED SPACE	0	387,764	8,043	395,807	4	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	8,349	0	8,349	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	11,217	0	11,217	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	13	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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	2,885,117	966,192	3,851,309	7,755	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		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						4.00
5.01	00520	DATA PROCESSING	163,198					5.01
5.02	00530	PURCHASING RECEIVING AND STORES	2,540	72,508				5.02
5.03	00540	ADMITTING	4,543	111	58,554			5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	148	0	18,082		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	14,731	791	0	0	300,318	5.05
7.00	00700	OPERATION OF PLANT	0	1,507	0	0	16,506	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50	0	0	1,821	8.00
9.00	00900	HOUSEKEEPING	452	1,349	0	0	6,271	9.00
10.00	01000	DIETARY	1,016	831	0	0	10,348	10.00
11.00	01100	CAFETERIA	282	0	0	0	18	11.00
13.00	01300	NURSING ADMINISTRATION	0	3	0	0	1,887	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	439	0	0	376	14.00
15.00	01500	PHARMACY	9,595	131	0	0	5,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,736	79	0	0	5,792	16.00
17.00	01700	SOCIAL SERVICE	339	1	0	0	2,728	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,079	3,706	3,395	995	32,925	30.00
43.00	04300	NURSERY	0	12	301	88	2,542	43.00
44.00	04400	SKILLED NURSING FACILITY	4,092	792	2,202	645	16,934	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,394	22,155	11,630	3,408	41,123	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	372	109	800	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,914	4,303	11,858	3,512	30,820	54.00
60.00	06000	LABORATORY	5,418	8,907	6,531	1,914	18,954	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	247	72	1,554	62.00
64.00	06400	INTRAVENOUS THERAPY	0	155	3,068	899	1,096	64.00
66.00	06600	PHYSICAL THERAPY	4,289	479	3,751	1,099	17,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,007	65	1,226	359	5,280	67.00
68.00	06800	SPEECH PATHOLOGY	903	7	179	52	1,153	68.00
69.00	06900	ELECTROCARDIOLOGY	2,060	317	2,155	615	7,315	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	267	78	37	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,409	1,700	498	11,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,190	642	7,059	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	88	596	175	1,840	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	41,935	1,920	0	100	10,094	90.00
90.01	09001	OB CLINIC	0	816	0	29	3,242	90.01
91.00	09100	EMERGENCY	11,091	2,070	5,355	938	19,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,782	709	0	246	8,345	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	163,198	72,350	57,023	16,473	291,346	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	198	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	170	192.00
192.02	19201	ORTHO CLINIC	0	95	0	0	1,563	192.02
192.03	19202	LEASED SPACE	0	21	0	0	5,190	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	91	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	1,160	322	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	122	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,531	449	215	194.03
194.04	07953	SPECIALTY CLINIC	0	42	0	0	1,101	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	163,198	72,508	58,554	18,082	300,318	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	289,876					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,069	18,355				8.00
9.00	00900	HOUSEKEEPING	5,022	1,617	46,484			9.00
10.00	01000	DIETARY	16,113	106	2,751	136,800		10.00
11.00	01100	CAFETERIA	0	0	132	91,311	91,743	11.00
13.00	01300	NURSING ADMINISTRATION	1,622	0	0	0	620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,587	0	155	0	1,510	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,259	0	333	0	5,199	16.00
17.00	01700	SOCIAL SERVICE	1,530	0	233	0	1,904	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,951	4,026	10,884	11,625	17,309	30.00
43.00	04300	NURSERY	0	0	227	0	1,487	43.00
44.00	04400	SKILLED NURSING FACILITY	52,090	5,765	9,723	33,864	14,161	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,097	2,682	6,829	0	13,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,029	0	0	0	603	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,737	1,255	562	0	6,619	54.00
60.00	06000	LABORATORY	8,215	0	821	0	7,047	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	255	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,543	0	0	0	180	64.00
66.00	06600	PHYSICAL THERAPY	26,668	1,216	2,060	0	10,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,373	0	626	0	2,726	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	580	68.00
69.00	06900	ELECTROCARDIOLOGY	6,411	0	838	0	2,625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	1,993	130	574	0	704	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	11,811	0	0	0	0	90.01
91.00	09100	EMERGENCY	12,070	1,558	562	0	4,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,426	0	255	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	283,871	18,355	37,565	136,800	91,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,891	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	304	192.02
192.03	19202	LEASED SPACE	0	0	8,919	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	1,329	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	1,785	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	289,876	18,355	46,484	136,800	91,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	14,761					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	815				14.00
15.00	01500	PHARMACY	420	0	46,960			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	68,447		16.00
17.00	01700	SOCIAL SERVICE	530	0	0	0	17,000	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,815	0	0	3,853	4,021	30.00
43.00	04300	NURSERY	414	0	0	342	379	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	2,499	11,473	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,757	0	0	13,198	89	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168	0	0	422	3	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,470	0	54.00
60.00	06000	LABORATORY	1,961	0	0	7,412	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	280	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,481	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,256	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,392	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,383	36	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	815	0	303	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,929	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	46,960	2,485	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	677	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	296	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,273	0	0	3,632	498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,423	0	0	0	205	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,761	815	46,960	62,217	17,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	4,492	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	1,738	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	14,761	815	46,960	68,447	17,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00520	DATA PROCESSING					5.01
5.02	00530	PURCHASING RECEIVING AND STORES					5.02
5.03	00540	ADMITTING					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	497,758	0	497,758		30.00
43.00	04300	NURSERY	12,635	0	12,635		43.00
44.00	04400	SKILLED NURSING FACILITY	515,630	0	515,630		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	658,345	0	658,345		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,563	0	24,563		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,246	0	584,246		54.00
60.00	06000	LABORATORY	132,824	0	132,824		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,010	0	4,010		62.00
64.00	06400	INTRAVENOUS THERAPY	20,138	0	20,138		64.00
66.00	06600	PHYSICAL THERAPY	265,510	0	265,510		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,889	0	25,889		67.00
68.00	06800	SPEECH PATHOLOGY	3,124	0	3,124		68.00
69.00	06900	ELECTROCARDIOLOGY	107,171	0	107,171		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,500	0	1,500		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,376	0	36,376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,336	0	59,336		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	23,075	0	23,075		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	105,045	0	105,045		90.00
90.01	09001	OB CLINIC	98,086	0	98,086		90.01
91.00	09100	EMERGENCY	158,876	0	158,876		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	40,473	0	40,473		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,374,610	0	3,374,610		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,251	0	21,251		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	170	0	170		192.00
192.02	19201	ORTHO CLINIC	11,381	0	11,381		192.02
192.03	19202	LEASED SPACE	409,941	0	409,941		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	9,769	0	9,769		194.00
194.01	07950	PHYSICIAN BILLING COSTS	5,974	0	5,974		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	13,124	0	13,124		194.02
194.03	07952	ANESTHESIA BILLNG	3,933	0	3,933		194.03
194.04	07953	SPECIALTY CLINIC	1,156	0	1,156		194.04
194.05	07954	COLONA CLINIC	0	0	0		194.05
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)	3,851,309	0	3,851,309		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	145,832					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		953,111				2.00
4.00	00400	EMPLOYEE BENEFITS	392	0	11,703,767			4.00
5.01	00520	DATA PROCESSING	2,296	115,938	369,287	144,575		5.01
5.02	00530	PURCHASING RECEIVING AND STORES	3,533	0	109,084	2,250	3,547,699	5.02
5.03	00540	ADMITTING	1,969	14,633	168,463	4,025	5,424	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	845	1,038	249,053	0	7,238	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	12,533	35,957	593,959	13,050	38,712	5.05
7.00	00700	OPERATION OF PLANT	12,606	22,041	186,793	0	73,758	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	657	1,378	30,374	0	2,458	8.00
9.00	00900	HOUSEKEEPING	1,595	0	329,110	400	65,998	9.00
10.00	01000	DIETARY	5,117	4,044	453,499	900	40,659	10.00
11.00	01100	CAFETERIA	0	0	0	250	0	11.00
13.00	01300	NURSING ADMINISTRATION	515	354	122,221	0	165	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	21,469	14.00
15.00	01500	PHARMACY	1,139	3,503	168,992	8,500	6,428	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,670	8,703	283,416	8,625	3,874	16.00
17.00	01700	SOCIAL SERVICE	486	0	180,250	300	43	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,593	35,844	1,717,422	24,875	181,309	30.00
43.00	04300	NURSERY	0	6,640	168,460	0	597	43.00
44.00	04400	SKILLED NURSING FACILITY	16,543	33,114	810,744	3,625	38,753	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,592	171,807	1,275,608	6,550	1,083,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	962	0	37,629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,856	319,943	665,291	6,125	210,540	54.00
60.00	06000	LABORATORY	2,609	13,466	568,026	4,800	435,803	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	81	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	490	0	32,820	0	7,584	64.00
66.00	06600	PHYSICAL THERAPY	8,469	25,646	1,025,551	3,800	23,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	436	0	314,602	3,550	3,198	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	70,765	800	350	68.00
69.00	06900	ELECTROCARDIOLOGY	2,036	41,378	285,905	1,825	15,530	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	998,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	633	3,680	66,895	0	4,295	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	49,816	301,211	37,150	93,921	90.00
90.01	09001	OB CLINIC	3,751	7,812	91,203	0	39,933	90.01
91.00	09100	EMERGENCY	3,833	18,916	517,806	9,825	101,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,088	247	463,627	3,350	34,679	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	124,325	935,898	11,658,066	144,575	3,540,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	918	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	9,279	19,711	0	4,645	192.02
192.03	19202	LEASED SPACE	19,600	7,934	6,711	0	1,004	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	422	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	567	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	19,279	0	2,047	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,885,117	966,192	3,687,920	946,114	227,953	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.783840	1.013725	0.315105	6.544105	0.064254	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
204.00		Cost to be allocated (per Wkst. B, Part II)			7,755	163,198	72,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000663	1.128812	0.020438	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		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						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING	62,189,513					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	65,402,541				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-2,733,297	27,512,296		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,512,121	92,058	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	166,847	657	8.00
9.00	00900	HOUSEKEEPING	0	0	0	574,514	1,595	9.00
10.00	01000	DIETARY	0	0	0	948,001	5,117	10.00
11.00	01100	CAFETERIA	0	0	0	1,636	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	172,898	515	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	34,428	0	14.00
15.00	01500	PHARMACY	0	0	0	491,451	1,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	530,626	1,670	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	249,887	486	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,604,551	3,604,551	0	3,016,199	14,593	30.00
43.00	04300	NURSERY	319,755	319,755	0	232,834	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,337,322	2,337,322	0	1,551,283	16,543	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,346,044	12,346,044	0	3,767,773	15,592	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	394,991	394,991	0	73,303	962	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,618,934	12,618,934	0	2,823,364	7,856	54.00
60.00	06000	LABORATORY	6,933,543	6,933,543	0	1,736,385	2,609	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	262,131	262,131	0	142,339	81	62.00
64.00	06400	INTRAVENOUS THERAPY	3,256,411	3,256,411	0	100,372	490	64.00
66.00	06600	PHYSICAL THERAPY	3,981,522	3,981,522	0	1,591,774	8,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,301,946	1,301,946	0	483,669	436	67.00
68.00	06800	SPEECH PATHOLOGY	189,631	189,631	0	105,603	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,287,309	2,229,413	0	670,099	2,036	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	283,049	283,049	0	3,429	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,804,510	1,804,510	0	1,084,617	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,324,381	2,324,381	0	646,699	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	633,016	633,016	0	168,601	633	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	360,923	0	924,685	0	90.00
90.01	09001	OB CLINIC	0	103,440	0	296,958	3,751	90.01
91.00	09100	EMERGENCY	5,684,723	3,397,556	0	1,823,440	3,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	891,215	0	764,488	1,088	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,563,769	59,574,284	-2,733,297	26,690,323	90,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,162	918	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	15,559	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	143,164	0	192.02
192.03	19202	LEASED SPACE	0	0	0	475,477	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	8,349	422	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	4,202,513	0	29,481	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	11,217	567	194.02
194.03	07952	ANESTHESIA BILLNG	1,625,744	1,625,744	0	19,693	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	100,871	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	317,045	458,793		2,733,297	1,662,347	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005098	0.007015		0.099348	18.057605	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	58,554	18,082		300,318	289,876	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000942	0.000276		0.010916	3.148841	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			8.00	9.00	10.00	11.00	13.00	
		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						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	261,410					8.00
9.00	00900	HOUSEKEEPING	23,031	538,100				9.00
10.00	01000	DIETARY	1,510	31,850	157,647			10.00
11.00	01100	CAFETERIA	0	1,525	105,226	16,287		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	110	9,418	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,800	0	268	268	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,850	0	923	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,700	0	338	338	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,343	126,000	13,396	3,073	3,073	30.00
43.00	04300	NURSERY	0	2,625	0	264	264	43.00
44.00	04400	SKILLED NURSING FACILITY	82,110	112,550	39,025	2,514	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,190	79,050	0	2,397	2,397	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	107	107	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,869	6,500	0	1,175	0	54.00
60.00	06000	LABORATORY	0	9,500	0	1,251	1,251	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	32	0	64.00
66.00	06600	PHYSICAL THERAPY	17,321	23,850	0	1,791	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,250	0	484	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,700	0	466	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	1,845	6,650	0	125	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	22,191	6,500	0	812	812	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,950	0	0	908	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	261,410	434,850	157,647	16,233	9,418	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	54	0	192.02
192.03	19202	LEASED SPACE	0	103,250	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
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)	195,287	677,598	1,175,819	788,553	204,701	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.747053	1.259242	7.458556	48.416099	21.735082	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,355	46,484	136,800	91,743	14,761	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
		8.00	9.00	10.00	11.00	13.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.070215	0.086385	0.867762	5.632897	1.567318	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	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						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	64,046,963			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	153,575		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,604,551	36,325		30.00
43.00	04300	NURSERY	0	0	319,755	3,425		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,337,322	103,650		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	12,346,044	800		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	394,991	25		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,618,934	0		54.00
60.00	06000	LABORATORY	0	0	6,933,543	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	262,131	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,256,411	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	3,981,522	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,301,946	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	189,631	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,229,413	325		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	283,049	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,804,510	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	2,324,381	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	633,016	0		76.01
76.02	03021	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	0	0	2,675		90.00
90.01	09001	OB CLINIC	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	3,397,556	4,500		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,850		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	58,218,706	153,575		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.02	19201	ORTHO CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	0	0	0		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	4,202,513	0		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,625,744	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
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)	37,848	581,912	663,035	310,600		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	378.480000	5,819.120000	0.010352	2.022465		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	16.00	17.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	815	46,960	68,447	17,000		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.150000	469.600000	0.001069	0.110695		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

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	4,207,136		4,207,136	0	4,207,136	30.00
43.00	04300	NURSERY	288,029		288,029	0	288,029	43.00
44.00	04400	SKILLED NURSING FACILITY	2,853,807		2,853,807	0	2,853,807	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,849,301		4,849,301	0	4,849,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,604		109,604	0	109,604	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,454,797		3,454,797	0	3,454,797	54.00
60.00	06000	LABORATORY	2,127,502		2,127,502	0	2,127,502	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	160,657		160,657	0	160,657	62.00
64.00	06400	INTRAVENOUS THERAPY	154,451		154,451	0	154,451	64.00
66.00	06600	PHYSICAL THERAPY	2,073,747	0	2,073,747	0	2,073,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	585,635	0	585,635	0	585,635	67.00
68.00	06800	SPEECH PATHOLOGY	123,044	0	123,044	0	123,044	68.00
69.00	06900	ELECTROCARDIOLOGY	831,950		831,950	0	831,950	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,548		44,548	0	44,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,211,052		1,211,052	0	1,211,052	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,316,921		1,316,921	0	1,316,921	73.00
76.00	03022	ACUPUNCTURE	0		0	0	0	76.00
76.01	03020	SLEEP LAB	219,138		219,138	0	219,138	76.01
76.02	03021	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	1,021,961		1,021,961	0	1,021,961	90.00
90.01	09001	OB CLINIC	394,194		394,194	0	394,194	90.01
91.00	09100	EMERGENCY	2,199,808		2,199,808	0	2,199,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	564,604		564,604		564,604	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	887,277		887,277		887,277	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,679,163	0	29,679,163	0	29,679,163	200.00
201.00		Less Observation Beds	564,604		564,604		564,604	201.00
202.00		Total (see instructions)	29,114,559	0	29,114,559	0	29,114,559	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

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	3,055,821		3,055,821			30.00
43.00	04300	NURSERY	319,755		319,755			43.00
44.00	04400	SKILLED NURSING FACILITY	2,337,322		2,337,322			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,655,279	8,690,766	12,346,045	0.392782	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	335,147	59,844	394,991	0.277485	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772,155	11,846,779	12,618,934	0.273779	0.000000	54.00
60.00	06000	LABORATORY	1,053,188	5,880,355	6,933,543	0.306842	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	147,984	114,147	262,131	0.612888	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,409,742	846,669	3,256,411	0.047430	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	688,172	3,293,350	3,981,522	0.520843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,302	921,644	1,301,946	0.449815	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,885	116,746	189,631	0.648860	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	137,764	2,091,649	2,229,413	0.373170	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,400	50,649	283,049	0.157386	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,347,407	457,103	1,804,510	0.671125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,263,453	1,060,928	2,324,381	0.566568	0.000000	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03020	SLEEP LAB	0	633,016	633,016	0.346181	0.000000	76.01
76.02	03021	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	360,923	360,923	2.831521	0.000000	90.00
90.01	09001	OB CLINIC	0	103,440	103,440	3.810847	0.000000	90.01
91.00	09100	EMERGENCY	138,009	3,259,546	3,397,555	0.647468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	22,367	526,364	548,731	1.028927	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	891,215	891,215			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,369,152	41,205,133	59,574,285			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,369,152	41,205,133	59,574,285			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03022	ACUPUNCTURE	0.000000		76.00
76.01	03020	SLEEP LAB	0.000000		76.01
76.02	03021	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	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			
99.10	09910	CORF			99.10
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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,207,136		4,207,136	0	0	30.00
43.00	04300	NURSERY	288,029		288,029	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,853,807		2,853,807	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,849,301		4,849,301	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,604		109,604	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,454,797		3,454,797	0	0	54.00
60.00	06000	LABORATORY	2,127,502		2,127,502	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	160,657		160,657	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	154,451		154,451	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,073,747	0	2,073,747	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	585,635	0	585,635	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	123,044	0	123,044	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	831,950		831,950	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,548		44,548	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,211,052		1,211,052	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,316,921		1,316,921	0	0	73.00
76.00	03022	ACUPUNCTURE	0		0	0	0	76.00
76.01	03020	SLEEP LAB	219,138		219,138	0	0	76.01
76.02	03021	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	1,021,961		1,021,961	0	0	90.00
90.01	09001	OB CLINIC	394,194		394,194	0	0	90.01
91.00	09100	EMERGENCY	2,199,808		2,199,808	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	564,604		564,604		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	887,277		887,277		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,679,163	0	29,679,163	0	0	200.00
201.00		Less Observation Beds	564,604		564,604		0	201.00
202.00		Total (see instructions)	29,114,559	0	29,114,559	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

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	3,055,821		3,055,821			30.00
43.00	04300	NURSERY	319,755		319,755			43.00
44.00	04400	SKILLED NURSING FACILITY	2,337,322		2,337,322			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,655,279	8,690,766	12,346,045	0.392782	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	335,147	59,844	394,991	0.277485	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772,155	11,846,779	12,618,934	0.273779	0.000000	54.00
60.00	06000	LABORATORY	1,053,188	5,880,355	6,933,543	0.306842	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	147,984	114,147	262,131	0.612888	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,409,742	846,669	3,256,411	0.047430	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	688,172	3,293,350	3,981,522	0.520843	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,302	921,644	1,301,946	0.449815	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,885	116,746	189,631	0.648860	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	137,764	2,091,649	2,229,413	0.373170	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,400	50,649	283,049	0.157386	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,347,407	457,103	1,804,510	0.671125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,263,453	1,060,928	2,324,381	0.566568	0.000000	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03020	SLEEP LAB	0	633,016	633,016	0.346181	0.000000	76.01
76.02	03021	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	360,923	360,923	2.831521	0.000000	90.00
90.01	09001	OB CLINIC	0	103,440	103,440	3.810847	0.000000	90.01
91.00	09100	EMERGENCY	138,009	3,259,546	3,397,555	0.647468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	22,367	526,364	548,731	1.028927	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	891,215	891,215			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,369,152	41,205,133	59,574,285			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,369,152	41,205,133	59,574,285			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet C Part I Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03022	ACUPUNCTURE	0.000000		76.00
76.01	03020	SLEEP LAB	0.000000		76.01
76.02	03021	IV THERAPY	0.000000		76.02
		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	OB CLINIC	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			
99.10	09910	CORF			99.10
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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part II Date/Time Prepared: 8/20/2013 1:02 pm

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	658,345	12,346,045	0.053324	1,922,714	102,527	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,563	394,991	0.062186	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,246	12,618,934	0.046299	349,583	16,185	54.00
60.00	06000	LABORATORY	132,824	6,933,543	0.019157	433,274	8,300	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,010	262,131	0.015298	103,281	1,580	62.00
64.00	06400	INTRAVENOUS THERAPY	20,138	3,256,411	0.006184	1,189,423	7,355	64.00
66.00	06600	PHYSICAL THERAPY	265,510	3,981,522	0.066686	152,138	10,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,889	1,301,946	0.019885	76,375	1,519	67.00
68.00	06800	SPEECH PATHOLOGY	3,124	189,631	0.016474	14,044	231	68.00
69.00	06900	ELECTROCARDIOLOGY	107,171	2,229,413	0.048071	95,004	4,567	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,500	283,049	0.005299	186,153	986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,376	1,804,510	0.020158	901,544	18,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,336	2,324,381	0.025528	528,712	13,497	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	23,075	633,016	0.036452	0	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	105,045	360,923	0.291045	0	0	90.00
90.01	09001	OB CLINIC	98,086	103,440	0.948241	0	0	90.01
91.00	09100	EMERGENCY	158,876	3,397,555	0.046762	3,541	166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	548,731	0.000000	4,399	0	92.00
200.00		Total (lines 50-199)	2,308,114	52,970,172		5,960,185	185,231	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	12,346,045	0.000000	0.000000	1,922,714	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	394,991	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,618,934	0.000000	0.000000	349,583	54.00
60.00	06000	LABORATORY	0	6,933,543	0.000000	0.000000	433,274	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	262,131	0.000000	0.000000	103,281	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,256,411	0.000000	0.000000	1,189,423	64.00
66.00	06600	PHYSICAL THERAPY	0	3,981,522	0.000000	0.000000	152,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,301,946	0.000000	0.000000	76,375	67.00
68.00	06800	SPEECH PATHOLOGY	0	189,631	0.000000	0.000000	14,044	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,229,413	0.000000	0.000000	95,004	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	283,049	0.000000	0.000000	186,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,804,510	0.000000	0.000000	901,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,324,381	0.000000	0.000000	528,712	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	633,016	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	360,923	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	103,440	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	3,397,555	0.000000	0.000000	3,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	548,731	0.000000	0.000000	4,399	92.00
200.00		Total (lines 50-199)	0	52,970,172			5,960,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		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	OB CLINIC	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V Date/Time Prepared: 8/20/2013 1:02 pm

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	0.392782	0	2,497,805	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	394	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	0	3,988,718	0	0	54.00
60.00	06000	LABORATORY	0.306842	0	2,495,954	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	0	86,483	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	0	421,470	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	0	966,438	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	0	216,237	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	0	24,882	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	0	1,076,571	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	0	23,336	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	0	27,900	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	0	456,268	7,422	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	179,533	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.831521	0	43,404	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.647468	0	1,185,328	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	0	262,779	0	0	92.00
200.00		Subtotal (see instructions)		0	13,953,500	7,422	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	13,953,500	7,422	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V Date/Time Prepared: 8/20/2013 1:02 pm

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	981,093	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,027	0		54.00
60.00	06000	LABORATORY	765,864	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	53,004	0		62.00
64.00	06400	INTRAVENOUS THERAPY	19,990	0		64.00
66.00	06600	PHYSICAL THERAPY	503,362	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	97,267	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,145	0		68.00
69.00	06900	ELECTROCARDIOLOGY	401,744	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,673	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,724	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,507	4,205		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	62,151	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	122,899	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
91.00	09100	EMERGENCY	767,462	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	270,380	0		92.00
200.00		Subtotal (see instructions)	5,434,401	4,205		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,434,401	4,205		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.392782	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	0	0	0	0	54.00
60.00	06000	LABORATORY	0.306842	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	0	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.831521	0	0	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.647468	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		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	OB CLINIC	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	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: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	12,346,045	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	394,991	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,618,934	0.000000	0.000000	13,271	54.00
60.00	06000	LABORATORY	0	6,933,543	0.000000	0.000000	22,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	262,131	0.000000	0.000000	3,952	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,256,411	0.000000	0.000000	23,408	64.00
66.00	06600	PHYSICAL THERAPY	0	3,981,522	0.000000	0.000000	280,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,301,946	0.000000	0.000000	175,610	67.00
68.00	06800	SPEECH PATHOLOGY	0	189,631	0.000000	0.000000	46,583	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,229,413	0.000000	0.000000	2,302	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	283,049	0.000000	0.000000	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,804,510	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,324,381	0.000000	0.000000	105,586	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	633,016	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	360,923	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	103,440	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	3,397,555	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	548,731	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	52,970,172			673,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

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	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		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	OB CLINIC	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: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 1:02 pm

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	0.392782	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	0	0	0	0	54.00
60.00	06000	LABORATORY	0.306842	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	0	0	248	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	0	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.831521	0	0	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.647468	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	248	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	248	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/20/2013 1:02 pm

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	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	141		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		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	OB CLINIC	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	141		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	141		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part I Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	497,758	0	497,758	4,134	120.41	30.00
43.00	NURSERY	12,635		12,635	435	29.05	43.00
44.00	SKILLED NURSING FACILITY	515,630		515,630	13,052	39.51	44.00
200.00	Total (lines 30-199)	1,026,023		1,026,023	17,621		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	417	50,211		30.00
43.00	NURSERY	214	6,217		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	631	56,428		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part II Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | 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	658,345	12,346,045	0.053324	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,563	394,991	0.062186	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,246	12,618,934	0.046299	0	0	54.00
60.00	06000	LABORATORY	132,824	6,933,543	0.019157	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,010	262,131	0.015298	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	20,138	3,256,411	0.006184	0	0	64.00
66.00	06600	PHYSICAL THERAPY	265,510	3,981,522	0.066686	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,889	1,301,946	0.019885	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,124	189,631	0.016474	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,171	2,229,413	0.048071	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,500	283,049	0.005299	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,376	1,804,510	0.020158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,336	2,324,381	0.025528	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	23,075	633,016	0.036452	0	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	105,045	360,923	0.291045	0	0	90.00
90.01	09001	OB CLINIC	98,086	103,440	0.948241	0	0	90.01
91.00	09100	EMERGENCY	158,876	3,397,555	0.046762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	548,731	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,308,114	52,970,172		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part III Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,134	0.00	417	0		30.00
43.00	04300	NURSERY	435	0.00	214	0		43.00
44.00	04400	SKILLED NURSING FACILITY	13,052	0.00	0	0		44.00
200.00		Total (lines 30-199)	17,621		631	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | 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	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | 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	12,346,045	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	394,991	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,618,934	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	6,933,543	0.000000	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	262,131	0.000000	0.000000	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,256,411	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	3,981,522	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,301,946	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	189,631	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,229,413	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	283,049	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,804,510	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,324,381	0.000000	0.000000	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	633,016	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	360,923	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	103,440	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	3,397,555	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	548,731	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	52,970,172			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title XIX | 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	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		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	OB CLINIC	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 INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part I Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	497,758	0	497,758	4,134	120.41	30.00
43.00	NURSERY	12,635		12,635	435	29.05	43.00
44.00	SKILLED NURSING FACILITY	515,630		515,630	13,052	39.51	44.00
200.00	Total (lines 30-199)	1,026,023		1,026,023	17,621		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part II Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

		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	658,345	0	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,563	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	584,246	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	132,824	0	0.000000	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,010	0	0.000000	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	20,138	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	265,510	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,889	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,124	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,171	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,500	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,376	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,336	0	0.000000	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	23,075	0	0.000000	0	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	105,045	0	0.000000	0	0	90.00
90.01	09001	OB CLINIC	98,086	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	158,876	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,308,114	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part III Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,134	0.00	0	0		30.00
43.00	04300	NURSERY	435	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	13,052	0.00	0	0		44.00
200.00		Total (lines 30-199)	17,621		0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

		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	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		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	OB CLINIC	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

		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	0	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	0	0.000000	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	0			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/20/2013 1:02 pm

Title V | Hospital

		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	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		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	OB CLINIC	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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 1:02 pm

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)	4,849	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,134	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,488	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	337	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)	337	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,876	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)	306	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)	306	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	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,207,136	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)	2,533	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)	2,413	25.00
26.00	Total swing-bed cost (see instructions)	594,022	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,613,114	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,604,551	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,604,551	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.002376	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,033.41	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)	3,613,114	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)	874.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,639,624	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)	1,639,624	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 1:02 pm

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						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)	2,202,454	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,842,078	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)	267,444	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	267,444	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	534,888	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)	646	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	874.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	564,604	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 1:02 pm

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: 141319 Component CCN: 145464	Period: From 06/01/2012 To 05/31/2013	Worksheet D-1 Date/Time Prepared: 8/20/2013 1:02 pm
	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)	13,052	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,052	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)	13,052	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)	1,340	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,853,807	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,853,807	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,337,322	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,337,322	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.220973	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)	179.08	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,853,807	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: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/20/2013 1:02 pm

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)	2,853,807	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	218.65	71.00
72.00	Program routine service cost (line 9 x line 71)	292,991	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)	292,991	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)	292,991	83.00
84.00	Program inpatient ancillary services (see instructions)	330,139	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)	623,130	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-1

Component CCN: 145464 | Date/Time Prepared: 8/20/2013 1:02 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/20/2013 1:02 pm

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		1,535,755		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392782	1,922,714	755,207	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	349,583	95,708	54.00
60.00	06000	LABORATORY	0.306842	433,274	132,947	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	103,281	63,300	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	1,189,423	56,414	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	152,138	79,240	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	76,375	34,355	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	14,044	9,113	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	95,004	35,453	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	186,153	29,298	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	901,544	605,049	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	528,712	299,551	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.831521	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	90.01
91.00	09100	EMERGENCY	0.647468	3,541	2,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	4,399	4,526	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,960,185	2,202,454	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)		5,960,185		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392782	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	16,667	4,563	54.00
60.00	06000	LABORATORY	0.306842	49,907	15,314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	6,028	3,694	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	95,947	4,551	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	126,169	65,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	65,066	29,268	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	3,920	2,544	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	3,115	1,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	1,878	296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	89,075	50,467	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.831521	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	90.01
91.00	09100	EMERGENCY	0.647468	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		457,772	177,573	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)		457,772		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/20/2013 1:02 pm

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392782	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.277485	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.273779	13,271	3,633	54.00
60.00	06000	LABORATORY	0.306842	22,624	6,942	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.612888	3,952	2,422	62.00
64.00	06400	INTRAVENOUS THERAPY	0.047430	23,408	1,110	64.00
66.00	06600	PHYSICAL THERAPY	0.520843	280,540	146,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449815	175,610	78,992	67.00
68.00	06800	SPEECH PATHOLOGY	0.648860	46,583	30,226	68.00
69.00	06900	ELECTROCARDIOLOGY	0.373170	2,302	859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.157386	100	16	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.671125	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566568	105,586	59,822	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.346181	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.831521	0	0	90.00
90.01	09001	OB CLINIC	3.810847	0	0	90.01
91.00	09100	EMERGENCY	0.647468	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.028927	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		673,976	330,139	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)		673,976		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2012 To 05/31/2013	Worksheet E Part B Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,438,606	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)	5,438,606	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)	5,492,992	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)	46,307	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,245,578	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)	3,201,107	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)	3,201,107	30.00
31.00	Primary payer payments	377	31.00
32.00	Subtotal (line 30 minus line 31)	3,200,730	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)	228,227	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	228,227	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	127,751	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,428,957	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,428,957	40.00
41.00	Interim payments	3,144,481	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	284,476	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2012 To 05/31/2013	Worksheet E Part B Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	141	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)	141	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	248	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)	248	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)	248	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	107	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)	141	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)	141	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)	141	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	141	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 (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	141	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	141	40.00
41.00	Interim payments	198	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-57	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,431,788		2,936,064	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	03/14/2013	1,388	11/26/2012	159,122	3.01
3.02		04/23/2013	178,375	03/14/2013	49,078	3.02
3.03			0	04/23/2013	217	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/26/2012	274,917		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)		-95,154		208,417	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)		3,336,634		3,144,481	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		37,776		284,476	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,374,410		3,428,957	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

Component CCN: 14Z319 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		860,502		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/26/2012	64,602		0	3.01
3.02		03/14/2013	12,668		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	04/23/2013	157,601		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)		-80,331		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)		780,171		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		69,441		0	6.02
7.00	Total Medicare program liability (see instructions)		710,730		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2012 To 05/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

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		454,910		198	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)		454,910		198	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		1		57	6.02
7.00	Total Medicare program liability (see instructions)		454,909		141	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141319	Period: From 06/01/2012 To 05/31/2013	Worksheet E-1 Part II Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,249	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,876	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	164	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,488	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	59,574,285	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	524,230	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	1,398,529	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,104,988	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,071,375	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	33,613	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141319 Component CCN: 14Z319	Period: From 06/01/2012 To 05/31/2013	Worksheet E-2 Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	540,237	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	179,349	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	612	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	719,586	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	719,586	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	719,586	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,856	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	710,730	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	710,730	0	19.00
20.00	Interim payments	780,171	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-69,441	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2012 To 05/31/2013	Worksheet E-3 Part V Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	3,842,078	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)	3,842,078	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,880,499	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)	3,880,499	19.00
20.00	Deductibles (exclude professional component)	549,876	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	3,330,623	22.00
23.00	Coinsurance	1,184	23.00
24.00	Subtotal (line 22 minus line 23)	3,329,439	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	44,971	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,971	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,976	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,374,410	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	3,374,410	30.00
31.00	Interim payments	3,336,634	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	37,776	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2012 To 05/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 8/20/2013 1:02 pm
	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)	546,015	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)	546,015	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	91,106	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	Allowable 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)	454,909	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	454,909	15.00
16.00	Interim payments	454,910	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	-1	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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet G | Date/Time Prepared: 8/20/2013 1:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,456,547	0	0	0	1.00
2.00	Temporary investments	983,483	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,525,852	0	0	0	4.00
5.00	Other receivable	1,453,570	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	802,727	0	0	0	7.00
8.00	Prepaid expenses	242,820	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	868,240	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,333,239	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	38,235,403	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,235,403	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,613,432	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	874,199	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,487,631	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,056,273	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	574,964	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,451,791	0	0	0	38.00
39.00	Payroll taxes payable	354,570	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,423,377	0	0	0	40.00
41.00	Deferred income	1,458,580	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	38,483	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,301,765	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,245,037	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	422,027	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	25,667,064	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	30,968,829	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,087,444				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)	29,087,444	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,056,273	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet G-1 | Date/Time Prepared: 8/20/2013 1:02 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,697,115		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		390,329				2.00
3.00	Total (sum of line 1 and line 2)		29,087,444		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)		29,087,444		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,087,444		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: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/20/2013 1:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,604,551		3,604,551	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	2,337,322		2,337,322	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,941,873		5,941,873	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,941,873		5,941,873	17.00
18.00	Ancillary services	13,180,246	37,062,917	50,243,163	18.00
19.00	Outpatient services	234,169	7,772,366	8,006,535	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		891,215	891,215	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	319,755	0	319,755	27.00
27.01	NRCC CLINICS	110,155	0	110,155	27.01
27.02		0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,786,198	45,726,498	65,512,696	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,863,557		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	OTHER OP LTC	132			37.00
38.00	EDUCATION CONTRACTS	1,112			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)		1,244		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,862,313		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet G-3 | Date/Time Prepared: 8/20/2013 1:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,512,696	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,661,708	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,850,988	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,862,313	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,011,325	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	55,638	6.00
7.00	Income from investments	142,561	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	686,995	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	EHR PAYMENTS	1,003,809	24.01
24.02	OTHER OP REV	609,837	24.02
24.03	CAPITAL CONTRIBUTIONS	334,958	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	2,833,798	25.00
26.00	Total (line 5 plus line 25)	822,473	26.00
27.00	LOSS ON DISPOSAL	48,071	27.00
27.01	CHARITY CARE	384,073	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	432,144	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	390,329	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H | Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	98,327	0	3,585	10,961	6,632	119,505	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	325,744	0	59,946	0	0	385,690	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	39,556	0	0	0	0	39,556	11.00
12.00	Supplies (see instructions)	0	0	0	0	30,348	30,348	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	463,627	0	63,531	10,961	36,980	575,099	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	119,505	-8,880	110,625			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	385,690	0	385,690			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	39,556	0	39,556			11.00
12.00	Supplies (see instructions)	0	30,348	0	30,348			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	575,099	-8,880	566,219			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: 141319 HHA CCN: 147450

Period: From 06/01/2012 To 05/31/2013

Worksheet H-1 Part I Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I

PPS

			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	110,625	0	0	0	0	110,625	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	385,690	0	0	0	0	385,690	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	39,556	0	0	0	0	39,556	11.00
12.00	Supplies (see instructions)	30,348	0	0	0	0	30,348	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	566,219	0	0	0	0	566,219	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	110,625						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	93,651	479,341					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	9,605	49,161					11.00
12.00	Supplies (see instructions)	7,369	37,717					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
24.00	Total (sum of lines 1-23)		566,219					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-1 Part II Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	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	-110,625	455,594	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	385,690	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	39,556	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	30,348	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-110,625	455,594	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		110,625	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.242815	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	21,525	250	146,091	21,923	2,228	1.00
2.00	Skilled Nursing Care	479,341	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	49,161	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	37,717	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	566,219	21,525	250	146,091	21,923	2,228	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	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	6,252	198,269	19,698	19,647	0	1.00
2.00	Skilled Nursing Care	0	0	479,341	47,621	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	49,161	4,884	0	0	7.00
8.00	Supplies (see instructions)	0	0	37,717	3,747	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	6,252	764,488	75,950	19,647	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.			0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-2 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,715	0	0	19,735	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	3,715	0	0	19,735	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

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	3,742	264,806	0	264,806		1.00
2.00	Skilled Nursing Care	0	0	526,962	0	526,962	224,176	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	54,045	0	54,045	22,991	7.00
8.00	Supplies (see instructions)	0	0	41,464	0	41,464	17,639	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	3,742	887,277	0	887,277	264,806	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.						0.425411	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: 141319 HHA CCN: 147450

Period: From 06/01/2012 To 05/31/2013

Worksheet H-2 Part I Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I

PPS

	Cost Center Description	Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	751,138		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	77,036		7.00
8.00	Supplies (see instructions)	59,103		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19) (2)	887,277		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 STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2012 To 05/31/2013

Worksheet H-2 Part II Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,088	247	463,627	3,350	34,679	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,088	247	463,627	3,350	34,679	0	20.00
21.00	Total cost to be allocated	21,525	250	146,091	21,923	2,228	0	21.00
22.00	Unit cost multiplier	19.784007	1.012146	0.315105	6.544179	0.064246	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	891,215	0	198,269	1,088	0	2,950	1.00
2.00	Skilled Nursing Care	0	0	479,341	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	49,161	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	37,717	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	891,215		764,488	1,088	0	2,950	20.00
21.00	Total cost to be allocated	6,252		75,950	19,647	0	3,715	21.00
22.00	Unit cost multiplier	0.007015		0.099348	18.057904	0.000000	1.259322	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2012 To 05/31/2013

Worksheet H-2 Part II Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I

PPS

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	908	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	908	0	0	0	20.00
21.00	Total cost to be allocated	0	0	19,735	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	21.734581	0.000000	0.000000	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)						
		17.00						
1.00	Administrative and General	1,850						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
20.00	Total (sum of lines 1-19)	1,850						20.00
21.00	Total cost to be allocated	3,742						21.00
22.00	Unit cost multiplier	2.022703						22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

HHA CCN: 147450 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (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	751,138		751,138	5,448	137.87	1.00
2.00	Physical Therapy	3.00	0	180,514	180,514	2,036	88.66	2.00
3.00	Occupational Therapy	4.00	0	104,439	104,439	1,341	77.88	3.00
4.00	Speech Pathology	5.00	0	18,295	18,295	195	93.82	4.00
5.00	Medical Social Services	6.00	0		0	27	0.00	5.00
6.00	Home Health Aide	7.00	77,036		77,036	1,871	41.17	6.00
7.00	Total (sum of lines 1-6)		828,174	303,248	1,131,422	10,918		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	1,296	2,654			8.00
8.01	Skilled Nursing Care		37900	0	0			8.01
8.02	Skilled Nursing Care		99914	218	62			8.02
8.03	Skilled Nursing Care		50208	0	0			8.03
8.04	Skilled Nursing Care		49740	14	14			8.04
9.00	Physical Therapy		19340	645	871			9.00
9.01	Physical Therapy		37900	0	0			9.01
9.02	Physical Therapy		99914	53	25			9.02
9.03	Physical Therapy		50208	0	0			9.03
9.04	Physical Therapy		49740	11	0			9.04
10.00	Occupational Therapy		19340	426	601			10.00
10.01	Occupational Therapy		37900	0	0			10.01
10.02	Occupational Therapy		99914	15	5			10.02
10.03	Occupational Therapy		50208	0	0			10.03
10.04	Occupational Therapy		49740	9	0			10.04
11.00	Speech Pathology		19340	72	70			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		99914	0	0			11.02
11.03	Speech Pathology		50208	0	0			11.03
11.04	Speech Pathology		49740	0	0			11.04
12.00	Medical Social Services		19340	6	23			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
12.03	Medical Social Services		50208	0	0			12.03
12.04	Medical Social Services		49740	0	0			12.04
13.00	Home Health Aide		19340	456	1,187			13.00
13.01	Home Health Aide		37900	0	0			13.01
13.02	Home Health Aide		99914	25	28			13.02
13.03	Home Health Aide		50208	0	0			13.03
13.04	Home Health Aide		49740	0	18			13.04
14.00	Total (sum of lines 8-13)			3,246	5,558			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	59,103	0	59,103	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	20	20	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-3 Part I | Date/Time Prepared: 8/20/2013 1:02 pm

HHA CCN: 147450 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,528	2,730		210,665	376,385		1.00
2.00	Physical Therapy	709	896		62,860	79,439		2.00
3.00	Occupational Therapy	450	606		35,046	47,195		3.00
4.00	Speech Pathology	72	70		6,755	6,567		4.00
5.00	Medical Social Services	6	23		0	0		5.00
6.00	Home Health Aide	481	1,233		19,803	50,763		6.00
7.00	Total (sum of lines 1-6)	3,246	5,558		335,129	560,349		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
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 141319 HHA CCN: 147450	Period: From 06/01/2012 To 05/31/2013	Worksheet H-3 Part I Date/Time Prepared: 8/20/2013 1:02 pm
	Title XVIII	Home Health Agency I	PPS

	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	587,050			1.00
2.00	Physical Therapy	142,299			2.00
3.00	Occupational Therapy	82,241			3.00
4.00	Speech Pathology	13,322			4.00
5.00	Medical Social Services	0			5.00
6.00	Home Health Aide	70,566			6.00
7.00	Total (sum of lines 1-6)	895,478			7.00

	Cost Center Description				
		12.00			
	Limitation Cost Computation				
8.00	Skilled Nursing Care				8.00
8.01	Skilled Nursing Care				8.01
8.02	Skilled Nursing Care				8.02
8.03	Skilled Nursing Care				8.03
8.04	Skilled Nursing Care				8.04
9.00	Physical Therapy				9.00
9.01	Physical Therapy				9.01
9.02	Physical Therapy				9.02
9.03	Physical Therapy				9.03
9.04	Physical Therapy				9.04
10.00	Occupational Therapy				10.00
10.01	Occupational Therapy				10.01
10.02	Occupational Therapy				10.02
10.03	Occupational Therapy				10.03
10.04	Occupational Therapy				10.04
11.00	Speech Pathology				11.00
11.01	Speech Pathology				11.01
11.02	Speech Pathology				11.02
11.03	Speech Pathology				11.03
11.04	Speech Pathology				11.04
12.00	Medical Social Services				12.00
12.01	Medical Social Services				12.01
12.02	Medical Social Services				12.02
12.03	Medical Social Services				12.03
12.04	Medical Social Services				12.04
13.00	Home Health Aide				13.00
13.01	Home Health Aide				13.01
13.02	Home Health Aide				13.02
13.03	Home Health Aide				13.03
13.04	Home Health Aide				13.04
14.00	Total (sum of lines 8-13)				14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-3 Part II Date/Time Prepared: 8/20/2013 1:02 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.520843	346,580	180,514	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.449815	232,182	104,439	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.648860	28,195	18,295	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.157386	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.566568	35	20	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141319 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-4 Part I-II
HHA CCN: 147450 | Date/Time Prepared: 8/20/2013 1:02 pm

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	302,635	566,832	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)	302,635	566,832	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	302,635	566,832	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	3,839	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)	-3,839	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	402,039	619,542	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	3,754	30,379	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	3,363	8,263	13.00
14.00	Total PPS Reimbursement - PEP Episodes	6,113	7,504	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	2,791	3,806	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	171	0	16.00
17.00	Total Other Payments	10	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)	414,402	669,494	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	414,402	669,494	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	414,402	669,494	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141319
HHA CCN: 147450

Period:
From 06/01/2012
To 05/31/2013

Worksheet H-4
Part I-II
Date/Time Prepared:
8/20/2013 1:02 pm

Title XVIII | Home Health Agency I | PPS

		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	414,402	669,494	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	414,402	669,494	31.00
32.00	Interim payments (see instructions)	414,402	669,494	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2012 To 05/31/2013 | Worksheet H-5 | Date/Time Prepared: 8/20/2013 1:02 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		414,402		669,494	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)		414,402		669,494	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		414,402		669,494	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141319 HHA CCN: 147450	Period: From 06/01/2012 To 05/31/2013	Worksheet H-5 Date/Time Prepared: 8/20/2013 1:02 pm
		Home Health Agency I	PPS

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