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: 141329	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 10/23/2013 9:53 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/23/2013 Time: 9:53 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (141329) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	9,613	93,195	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-26,675	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		56,475		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-17,062	149,670	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/23/2013 9:51 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	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	MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MORRISON SNF	145274	99914		08/13/1974	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	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	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 9:51 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 9:51 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/23/2013 9:51 am

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

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 9:51 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	232,215	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141329	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 10/23/2013 9:51 am

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/23/2013 9:51 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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	09/11/2013	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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/23/2013 9:51 am

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	CAMI	MEGLI	41.00
42.00	Enter the employer/company name of the cost report preparer.	MORRISON COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-772-5533	CMEGLI@MCHSTAFF.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/23/2013 9:51 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	09/11/2013			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.		CONTROLLER		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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/23/2013 9:51 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	7,176.00	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	7,176.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	7,176.00	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	38	13,870		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		63				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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/23/2013 9:51 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	123	17	177			1.00
2.00	HMO	15	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	1,807	0	1,992			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	270			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,930	17	2,439			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)	1,930	17	2,439	0.00	101.67	14.00
15.00	CAH visits	1,750	1,071	5,616			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	5,514	9,990	0.00	20.32	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	1,370	3,871	13,895	0.00	9.42	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	131.41	27.00
28.00	Observation Bed Days		5	69			28.00
29.00	Ambulance Trips	242					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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/23/2013 9:51 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	43	8	85	1.00
2.00	HMO			5			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	43	8	85	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 10/23/2013 9:51 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		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	08/01/2003	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	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	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	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 10/23/2013 9:51 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	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		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	653,721	36.50	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,791,142			207.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 10/23/2013 9:51 am

					Rural Health Clinic (RHC) I	Cost	
					1.00		
	Clinic Address and Identification						
1.00	Street				300 NORTH JACKSON STREET		1.00
			City		State	Zip Code	
			1.00		2.00	3.00	
2.00	City, State, Zip Code, County		MORRISON		IL	61270	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
					Grant Award	Date	
					1.00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)				0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00
7.00	Appalachian Regional Commission				0		7.00
8.00	Look-Alikes				0		8.00
9.00	OTHER (SPECIFY)				0		9.00
					1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00
			County				
			4.00				
2.00	City, State, Zip Code, County		WHITESIDE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	20:00	08:00	20:00	08:00	20:00	11.00

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

Provider CCN: 141329
Component CCN: 143981

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

Worksheet S-8

Date/Time Prepared:
10/23/2013 9:51 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 10/23/2013 9:51 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.864985	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,133,632	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,585,048	6.00
7.00	Medicaid cost (line 1 times line 6)	2,236,028	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,102,396	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,102,396	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	25,367	15,025	40,392	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	21,942	12,996	34,938	21.00
22.00	Partial payment by patients approved for charity care	2,076	5,003	7,079	22.00
23.00	Cost of charity care (line 21 minus line 22)	19,866	7,993	27,859	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)	865,453	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	94,690	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	770,763	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	666,698	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	694,557	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,796,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		527,806	527,806	-120,307	407,499	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		23,875	23,875	320,587	344,462	2.00
4.00	00400	EMPLOYEE BENEFITS	0	1,406,392	1,406,392	0	1,406,392	4.00
5.01	00510	PURCHASING	33,650	10,173	43,823	0	43,823	5.01
5.02	00511	PERSONNEL	85,562	8,267	93,829	0	93,829	5.02
5.03	00512	HOSPITAL BILLING	251,708	107,042	358,750	0	358,750	5.03
5.04	00513	NURSING HOME BILLING	59	25	84	0	84	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	257,031	806,398	1,063,429	213,050	1,276,479	5.05
7.00	00700	OPERATION OF PLANT	144,558	346,211	490,769	0	490,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,845	51,845	0	51,845	8.00
9.00	00900	HOUSEKEEPING	159,200	41,058	200,258	0	200,258	9.00
10.00	01000	DIETARY	193,143	115,565	308,708	0	308,708	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,351	542	122,893	0	122,893	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,636	20,921	39,557	0	39,557	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	167,406	37,270	204,676	0	204,676	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	1,441	322	1,763	0	1,763	16.01
17.00	01700	SOCIAL SERVICE	64,553	1,093	65,646	0	65,646	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,033,253	184,433	1,217,686	-4,534	1,213,152	30.00
44.00	04400	SKILLED NURSING FACILITY	655,436	120,726	776,162	-3,094	773,068	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,566	116,550	191,116	-6,703	184,413	50.00
53.00	05300	ANESTHESIOLOGY	0	39,927	39,927	0	39,927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,401	78,506	282,907	8,390	291,297	54.00
60.00	06000	LABORATORY	278,300	248,572	526,872	-49	526,823	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,962	30,414	32,376	-9,787	22,589	65.00
66.00	06600	PHYSICAL THERAPY	239,292	4,018	243,310	0	243,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	155,253	1,948	157,201	0	157,201	67.00
68.00	06800	SPEECH PATHOLOGY	1,867	1,678	3,545	0	3,545	68.00
69.00	06900	ELECTROCARDIOLOGY	2,733	6,655	9,388	0	9,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,099	19,099	17,415	36,514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,703	6,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,693	211,575	337,268	0	337,268	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	406,848	1,232,368	1,639,216	-176,812	1,462,404	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	401,402	701,194	1,102,596	-95,972	1,006,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	90,929	37,979	128,908	-3,863	125,045	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		145,024	145,024	-145,024	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,171,233	6,685,471	11,856,704	0	11,856,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	5,171,233	6,685,471	11,856,704	0	11,856,704	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-12,366	395,133		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,817	341,645		2.00
4.00	00400	EMPLOYEE BENEFITS	-3,492	1,402,900		4.00
5.01	00510	PURCHASING	0	43,823		5.01
5.02	00511	PERSONNEL	0	93,829		5.02
5.03	00512	HOSPITAL BILLING	-8,144	350,606		5.03
5.04	00513	NURSING HOME BILLING	0	84		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-89,329	1,187,150		5.05
7.00	00700	OPERATION OF PLANT	0	490,769		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,845		8.00
9.00	00900	HOUSEKEEPING	0	200,258		9.00
10.00	01000	DIETARY	-22,493	286,215		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	122,893		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	39,557		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,867	202,809		16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	1,763		16.01
17.00	01700	SOCIAL SERVICE	0	65,646		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,213,152		30.00
44.00	04400	SKILLED NURSING FACILITY	0	773,068		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-28,121	156,292		50.00
53.00	05300	ANESTHESIOLOGY	-869	39,058		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,342	283,955		54.00
60.00	06000	LABORATORY	-33,191	493,632		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-18	22,571		65.00
66.00	06600	PHYSICAL THERAPY	-5,825	237,485		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,201		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,545		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,118	4,270		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	36,514		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,703		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-20,561	316,707		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-52,684	1,409,720		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-89,469	917,155		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-314	124,731		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-384,020	11,472,684		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-384,020	11,472,684		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/23/2013 9:51 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,657		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	3,731		2.00
3.00	AMBULANCE SERVICES	95.00	0	3,295		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,390		4.00
	TOTALS		0	145,073		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,928		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,695		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	209,319		3.00
	TOTALS		0	279,942		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	307,892		1.00
	TOTALS		0	307,892		
	D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,703		1.00
	TOTALS		0	6,703		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	17,415		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	17,415		
	F - ACTIVITIES DIRECTOR					
1.00	ADULTS & PEDIATRICS	30.00	1,847	188		1.00
	TOTALS		1,847	188		
500.00	Grand Total: Increases		1,847	757,213		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/23/2013 9:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	145,024	11		1.00
2.00	LABORATORY	60.00	0	49	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	145,073			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	95,972	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	176,812	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	7,158	0		3.00
	TOTALS		0	279,942			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	307,892	9		1.00
	TOTALS		0	307,892			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	6,703	0		1.00
	TOTALS		0	6,703			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,569	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	1,059	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	9,787	0		3.00
	TOTALS		0	17,415			
	F - ACTIVITIES DIRECTOR						
1.00	SKILLED NURSING FACILITY	44.00	1,847	188	0		1.00
	TOTALS		1,847	188			
500.00	Grand Total: Decreases		1,847	757,213			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0	0	0	0	1.00
2.00	Land Improvements	560,517	2,972	0	2,972	0	2.00
3.00	Buildings and Fixtures	7,684,994	89,798	0	89,798	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,093,708	168,124	0	168,124	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,360,876	260,894	0	260,894	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,360,876	260,894	0	260,894	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	21,657	0	1.00
2.00	Land Improvements	563,489	0	2.00
3.00	Buildings and Fixtures	7,774,792	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,261,832	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,621,770	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,621,770	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 10/23/2013 9:51 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	527,806	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,875	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	551,681	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	527,806		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,875		2.00
3.00	Total (sum of lines 1-2)	0	551,681		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III | Date/Time Prepared: 10/23/2013 9:51 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,359,938	0	8,359,938	0.662343	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,261,832	0	4,261,832	0.337657	0	2.00
3.00	Total (sum of lines 1-2)	12,621,770	0	12,621,770	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	219,914	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	328,950	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	548,864	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	117,291	57,928	0	0	395,133	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,695	0	0	341,645	2.00
3.00	Total (sum of lines 1-2)	117,291	70,623	0	0	736,778	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/23/2013 9:51 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,366	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	A	-2,878	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,817	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-134,576			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	B	-21,290	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,867	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LAB OTHER REVENUE	B	-18,007	LABORATORY	60.00	0	33.00
34.00	INVESTMENT INCOME-OTHER	B	-356	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	34.00
35.00	INVESTMENT INCOME-OTHER	B	-314	AMBULANCE SERVICES	95.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/23/2013 9:51 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	INVESTMENT INCOME-OTHER	B	-800	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	INVESTMENT INCOME-OTHER	B	5	LABORATORY	60.00	0	37.00
38.00	OTHER REV -A&G	B	-1,456	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	38.00
39.00	OTHER REV - DIETARY	B	-1,203	DIETARY	10.00	0	39.00
40.00			0		0.00	0	40.00
41.00	OTHER REV -PHYSICAL THERAPY	B	-220	PHYSICAL THERAPY	66.00	0	41.00
42.00	NONALLOWABLE DUES	A	-4,632	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	42.00
43.00	PATIENT TELEPHONE - SALARIES	A	-4,694	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	43.00
44.00	PATIENT TELEPHONE - BENEFITS	A	-1,277	EMPLOYEE BENEFITS	4.00	0	44.00
45.00	PHYSICIAN BILLING SALARIES	A	-8,144	HOSPITAL BILLING	5.03	0	45.00
45.01	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-2,215	EMPLOYEE BENEFITS	4.00	0	45.01
45.02	ADVERTISING	A	-75,213	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	45.02
45.03	OTHER REV- EDUCATION	A	-100	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	45.03
45.04	SELF INSURANCE EXPENSE	A	-7,786	OPERATING ROOM	50.00	0	45.04
45.05	SELF INSURANCE EXPENSE	A	-869	ANESTHESIOLOGY	53.00	0	45.05
45.06	SELF INSURANCE EXPENSE	A	-6,542	RADIOLOGY-DIAGNOSTIC	54.00	0	45.06
45.07	SELF INSURANCE EXPENSE	A	-15,189	LABORATORY	60.00	0	45.07
45.08	SELF INSURANCE EXPENSE	A	-18	RESPIRATORY THERAPY	65.00	0	45.08
45.09	SELF INSURANCE EXPENSE	A	-5,605	PHYSICAL THERAPY	66.00	0	45.09
45.10			0		0.00	0	45.10
45.11	SELF INSURANCE EXPENSE	A	-157	ELECTROCARDIOLOGY	69.00	0	45.11
45.12	SELF INSURANCE EXPENSE	A	-20,561	DRUGS CHARGED TO PATIENTS	73.00	0	45.12
45.13	SELF INSURANCE EXPENSE	A	-4,132	EMERGENCY	91.00	0	45.13
45.14			0		0.00	0	45.14
45.15	SELF INSURANCE EXPENSE	A	-28,741	RURAL HEALTH CLINIC	88.00	0	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-384,020				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 10/23/2013 9:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	518,243	85,337	432,906	0	0	1.00
2.00	91.00	EMERGENCY	6,300	0	6,300	0	0	2.00
3.00	50.00	OPERATING ROOM	20,335	20,335	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	4,961	4,961	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	22,719	22,719	0	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	1,224	1,224	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			573,782	134,576	439,206		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	5.00
6.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	85,337		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	20,335		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,961		4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	22,719		5.00
6.00	88.00	RURAL HEALTH CLINIC	0	0	0	1,224		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	134,576		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/23/2013 9:51 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					7	1.00
2.00	Line 1 multiplied by 15 hours per week					105	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	16.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	84.64	67.74	50.81	33.87	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.87	33.87	25.41			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,101	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,101	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,101	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.75	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					7,114	22.00
23.00	Total salary equivalency (see instructions)					7,114	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					373	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					373	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					61	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					434	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					434	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/23/2013 9:51 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.74	50.81	33.87	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	7,114	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	434	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	7,548	63.00
64.00	Total cost of outside supplier services (from your records)	1,053	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	373	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	61	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	434	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	61	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	61	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	PURCHASING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	395,133	395,133				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	341,645		341,645			2.00
4.00	00400	EMPLOYEE BENEFITS	1,402,900	0	0	1,402,900		4.00
5.01	00510	PURCHASING	43,823	11,510	0	9,129	64,462	5.01
5.02	00511	PERSONNEL	93,829	3,660	0	23,212	734	5.02
5.03	00512	HOSPITAL BILLING	350,606	6,319	3,082	68,286	1,884	5.03
5.04	00513	NURSING HOME BILLING	84	639	0	16	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,187,150	19,067	24,970	69,730	3,448	5.05
7.00	00700	OPERATION OF PLANT	490,769	71,154	6,225	39,217	2,139	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,845	9,061	0	0	479	8.00
9.00	00900	HOUSEKEEPING	200,258	3,782	0	43,189	1,405	9.00
10.00	01000	DIETARY	286,215	10,483	243	52,398	1,564	10.00
11.00	01100	CAFETERIA	0	4,034	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,893	5,354	0	33,192	415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,557	3,537	0	5,056	12,768	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,809	8,326	1,092	45,415	1,820	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	1,763	680	0	391	0	16.01
17.00	01700	SOCIAL SERVICE	65,646	1,041	0	17,513	32	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,213,152	63,671	36,415	280,813	4,598	30.00
44.00	04400	SKILLED NURSING FACILITY	773,068	59,997	1,539	177,312	3,608	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	156,292	14,251	92,178	20,229	1,341	50.00
53.00	05300	ANESTHESIOLOGY	39,058	0	0	0	192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283,955	9,476	83,929	55,452	1,788	54.00
60.00	06000	LABORATORY	493,632	9,564	16,283	75,500	4,949	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	22,571	0	0	532	0	65.00
66.00	06600	PHYSICAL THERAPY	237,485	9,857	1,512	64,917	1,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	157,201	3,367	0	42,118	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,545	0	0	506	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,270	0	834	741	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,514	0	0	0	2,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,703	0	0	0	639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,707	3,292	6,678	34,099	639	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,409,720	35,318	7,776	110,373	5,811	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	917,155	8,510	9,809	108,896	6,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	124,731	19,183	49,080	24,668	3,736	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,472,684	395,133	341,645	1,402,900	64,462	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	11,472,684	395,133	341,645	1,402,900	64,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL	121,435					5.02
5.03	00512	HOSPITAL BILLING	6,050	436,227				5.03
5.04	00513	NURSING HOME BILLING	1	0	740			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	6,178	0	0	1,310,543	1,310,543	5.05
7.00	00700	OPERATION OF PLANT	3,475	0	0	612,979	79,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	61,385	7,916	8.00
9.00	00900	HOUSEKEEPING	3,827	0	0	252,461	32,558	9.00
10.00	01000	DIETARY	4,643	0	0	355,546	45,852	10.00
11.00	01100	CAFETERIA	0	0	0	4,034	520	11.00
13.00	01300	NURSING ADMINISTRATION	2,941	0	0	164,795	21,252	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448	0	0	61,366	7,914	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,024	0	0	263,486	33,980	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	35	0	0	2,869	370	16.01
17.00	01700	SOCIAL SERVICE	1,552	0	0	85,784	11,063	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,881	51,015	0	1,674,545	215,958	30.00
44.00	04400	SKILLED NURSING FACILITY	15,710	0	740	1,031,974	133,086	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,792	18,125	0	304,208	39,232	50.00
53.00	05300	ANESTHESIOLOGY	0	3,054	0	42,304	5,456	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,913	62,125	0	501,638	64,693	54.00
60.00	06000	LABORATORY	6,689	69,548	0	676,165	87,200	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	47	4,648	0	27,798	3,585	65.00
66.00	06600	PHYSICAL THERAPY	5,752	34,509	0	355,405	45,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,732	19,173	0	225,591	29,093	67.00
68.00	06800	SPEECH PATHOLOGY	45	433	0	4,529	584	68.00
69.00	06900	ELECTROCARDIOLOGY	66	3,176	0	9,087	1,172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,537	0	47,318	6,102	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,241	0	8,583	1,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,021	48,717	0	413,153	53,281	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,779	70,648	0	1,649,425	212,715	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	9,648	23,039	0	1,083,890	139,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,186	18,239	0	241,823	31,186	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,435	436,227	740	11,472,684	1,310,543	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	121,435	436,227	740	11,472,684	1,310,543	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	692,031					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,174	91,475				8.00
9.00	00900	HOUSEKEEPING	9,256	0	294,275			9.00
10.00	01000	DIETARY	25,653	0	1,584	428,635		10.00
11.00	01100	CAFETERIA	9,872	0	0	79,715	94,141	11.00
13.00	01300	NURSING ADMINISTRATION	13,101	0	3,437	0	1,771	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,656	0	4,992	0	10	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,376	0	5,347	0	4,764	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	1,665	0	960	0	50	16.01
17.00	01700	SOCIAL SERVICE	2,547	0	1,469	0	751	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	155,817	18,118	88,309	69,029	24,699	30.00
44.00	04400	SKILLED NURSING FACILITY	146,826	61,353	81,522	279,561	20,335	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,875	1,054	13,277	0	2,422	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,189	1,823	11,837	0	4,123	54.00
60.00	06000	LABORATORY	23,406	0	13,497	0	5,814	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,121	1,663	13,910	0	3,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,240	0	4,752	0	1,661	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	20	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	8,057	0	3,898	0	1,771	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	86,431	1,086	33,475	0	9,427	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	20,825	5,703	12,009	0	10,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	46,944	675	0	0	2,572	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	692,031	91,475	294,275	428,305	94,141	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	330	0	194.02
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)	692,031	91,475	294,275	428,635	94,141	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						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	204,356					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	82,938				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	327,953			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	5,914		16.01
17.00	01700	SOCIAL SERVICE	2,688	0	0	0	104,302	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88,139	838	38,352	0	47,573	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	5,914	56,729	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,633	40,441	13,626	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,296	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	46,704	0	0	54.00
60.00	06000	LABORATORY	0	0	52,285	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,494	0	0	65.00
66.00	06600	PHYSICAL THERAPY	12,513	0	25,943	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,923	0	14,413	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	57	0	325	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,388	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,418	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,306	0	36,624	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,636	40,669	53,120	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	37,280	990	17,320	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,181	0	13,712	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	204,356	82,938	327,953	5,914	104,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	204,356	82,938	327,953	5,914	104,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	PURCHASING					5.01
5.02	00511	PERSONNEL					5.02
5.03	00512	HOSPITAL BILLING					5.03
5.04	00513	NURSING HOME BILLING					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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,421,377	-14,758	2,406,619		30.00
44.00	04400	SKILLED NURSING FACILITY	1,817,300	0	1,817,300		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	457,768	0	457,768		50.00
53.00	05300	ANESTHESIOLOGY	50,056	0	50,056		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,007	0	654,007		54.00
60.00	06000	LABORATORY	858,367	0	858,367		60.00
64.00	06400	INTRAVENOUS THERAPY	0	27,513	27,513		64.00
65.00	06500	RESPIRATORY THERAPY	34,877	0	34,877		65.00
66.00	06600	PHYSICAL THERAPY	482,892	0	482,892		66.00
67.00	06700	OCCUPATIONAL THERAPY	289,673	0	289,673		67.00
68.00	06800	SPEECH PATHOLOGY	5,515	0	5,515		68.00
69.00	06900	ELECTROCARDIOLOGY	12,647	0	12,647		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,838	0	59,838		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,623	0	10,623		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	523,090	-12,755	510,335		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,119,984	0	2,119,984		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	1,328,247	0	1,328,247		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	346,093	0	346,093		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,472,354	0	11,472,354		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	330	0	330		194.02
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)	11,472,684	0	11,472,684		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/23/2013 9:51 am

		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	0	0	0	0	4.00
5.01	00510	PURCHASING	0	11,510	0	11,510	0	5.01
5.02	00511	PERSONNEL	0	3,660	0	3,660	0	5.02
5.03	00512	HOSPITAL BILLING	598	6,319	3,082	9,999	0	5.03
5.04	00513	NURSING HOME BILLING	0	639	0	639	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	19,067	24,970	44,037	0	5.05
7.00	00700	OPERATION OF PLANT	351	71,154	6,225	77,730	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,061	0	9,061	0	8.00
9.00	00900	HOUSEKEEPING	0	3,782	0	3,782	0	9.00
10.00	01000	DIETARY	960	10,483	243	11,686	0	10.00
11.00	01100	CAFETERIA	0	4,034	0	4,034	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,354	0	5,354	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,537	0	3,537	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,731	8,326	1,092	11,149	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	15	680	0	695	0	16.01
17.00	01700	SOCIAL SERVICE	0	1,041	0	1,041	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,855	63,671	36,415	122,941	0	30.00
44.00	04400	SKILLED NURSING FACILITY	611	59,997	1,539	62,147	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,148	14,251	92,178	151,577	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,001	9,476	83,929	105,406	0	54.00
60.00	06000	LABORATORY	0	9,564	16,283	25,847	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,627	0	0	20,627	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,857	1,512	11,369	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,367	0	3,367	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	834	834	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	5,292	3,292	6,678	15,262	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,470	35,318	7,776	59,564	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,528	8,510	9,809	24,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	19,183	49,080	68,263	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,187	395,133	341,645	869,965	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	133,187	395,133	341,645	869,965	0	202.00

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		Cost Center Description	PURCHASING	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	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	00510	PURCHASING	11,510					5.01
5.02	00511	PERSONNEL	131	3,791				5.02
5.03	00512	HOSPITAL BILLING	336	189	10,524			5.03
5.04	00513	NURSING HOME BILLING	0	0	0	639		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	616	193	0	0	44,846	5.05
7.00	00700	OPERATION OF PLANT	382	108	0	0	2,705	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86	0	0	0	271	8.00
9.00	00900	HOUSEKEEPING	251	119	0	0	1,114	9.00
10.00	01000	DIETARY	279	145	0	0	1,569	10.00
11.00	01100	CAFETERIA	0	0	0	0	18	11.00
13.00	01300	NURSING ADMINISTRATION	74	92	0	0	727	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,280	14	0	0	271	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	325	126	0	0	1,163	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	1	0	0	13	16.01
17.00	01700	SOCIAL SERVICE	6	48	0	0	379	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	821	781	1,230	0	7,389	30.00
44.00	04400	SKILLED NURSING FACILITY	644	490	0	639	4,554	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	239	56	437	0	1,342	50.00
53.00	05300	ANESTHESIOLOGY	34	0	74	0	187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319	153	1,498	0	2,214	54.00
60.00	06000	LABORATORY	884	209	1,677	0	2,984	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1	112	0	123	65.00
66.00	06600	PHYSICAL THERAPY	245	179	832	0	1,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116	462	0	996	67.00
68.00	06800	SPEECH PATHOLOGY	0	1	10	0	20	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2	77	0	40	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	405	0	206	0	209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	114	0	30	0	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	114	94	1,175	0	1,823	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,038	305	1,708	0	7,279	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,220	301	556	0	4,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	667	68	440	0	1,067	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,510	3,791	10,524	639	44,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	11,510	3,791	10,524	639	44,846	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	80,925					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,593	12,011				8.00
9.00	00900	HOUSEKEEPING	1,082	0	6,348			9.00
10.00	01000	DIETARY	3,000	0	34	16,713		10.00
11.00	01100	CAFETERIA	1,154	0	0	3,108	8,314	11.00
13.00	01300	NURSING ADMINISTRATION	1,532	0	74	0	156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,012	0	108	0	1	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,383	0	115	0	421	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	195	0	21	0	4	16.01
17.00	01700	SOCIAL SERVICE	298	0	32	0	66	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,220	2,379	1,905	2,692	2,182	30.00
44.00	04400	SKILLED NURSING FACILITY	17,170	8,056	1,759	10,900	1,796	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,078	138	286	0	214	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,712	239	255	0	364	54.00
60.00	06000	LABORATORY	2,737	0	291	0	513	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,821	218	300	0	309	66.00
67.00	06700	OCCUPATIONAL THERAPY	964	0	103	0	147	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2	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	942	0	84	0	156	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,107	143	722	0	833	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,435	749	259	0	923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,490	89	0	0	227	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,925	12,011	6,348	16,700	8,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	13	0	194.02
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)	80,925	12,011	6,348	16,713	8,314	202.00

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		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						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	8,009					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,223				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	15,682			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	929		16.01
17.00	01700	SOCIAL SERVICE	105	0	0	0	1,975	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,456	73	1,834	0	901	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	929	1,074	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	338	3,522	652	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,233	0	0	54.00
60.00	06000	LABORATORY	0	0	2,500	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	167	0	0	65.00
66.00	06600	PHYSICAL THERAPY	490	0	1,241	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	232	0	689	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	16	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	114	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	307	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247	0	1,751	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,318	3,542	2,539	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,461	86	828	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	360	0	656	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,009	7,223	15,682	929	1,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	8,009	7,223	15,682	929	1,975	202.00

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		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	00510	PURCHASING					5.01
5.02	00511	PERSONNEL					5.02
5.03	00512	HOSPITAL BILLING					5.03
5.04	00513	NURSING HOME BILLING					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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	166,804	0	166,804		30.00
44.00	04400	SKILLED NURSING FACILITY	110,158	0	110,158		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	162,879	0	162,879		50.00
53.00	05300	ANESTHESIOLOGY	405	0	405		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,393	0	115,393		54.00
60.00	06000	LABORATORY	37,642	0	37,642		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	21,030	0	21,030		65.00
66.00	06600	PHYSICAL THERAPY	19,572	0	19,572		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,076	0	7,076		67.00
68.00	06800	SPEECH PATHOLOGY	51	0	51		68.00
69.00	06900	ELECTROCARDIOLOGY	1,067	0	1,067		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,127	0	1,127		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	227	0	227		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,648	0	21,648		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	89,098	0	89,098		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	38,448	0	38,448		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	77,327	0	77,327		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	869,952	0	869,952		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	13	0	13		194.02
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)	869,965	0	869,965		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	PURCHASING (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	58,087					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		307,656				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	5,171,233			4.00
5.01	00510	PURCHASING	1,692	0	33,650	2,019		5.01
5.02	00511	PERSONNEL	538	0	85,562	23	5,052,021	5.02
5.03	00512	HOSPITAL BILLING	929	2,775	251,708	59	251,708	5.03
5.04	00513	NURSING HOME BILLING	94	0	59	0	59	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,803	22,486	257,031	108	257,031	5.05
7.00	00700	OPERATION OF PLANT	10,460	5,606	144,558	67	144,558	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	15	0	8.00
9.00	00900	HOUSEKEEPING	556	0	159,200	44	159,200	9.00
10.00	01000	DIETARY	1,541	219	193,143	49	193,143	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	787	0	122,351	13	122,351	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	18,636	400	18,636	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,224	983	167,406	57	167,406	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	100	0	1,441	0	1,441	16.01
17.00	01700	SOCIAL SERVICE	153	0	64,553	1	64,553	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,360	32,792	1,035,100	144	1,035,100	30.00
44.00	04400	SKILLED NURSING FACILITY	8,820	1,386	653,589	113	653,589	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,095	83,008	74,566	42	74,566	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	75,579	204,401	56	204,401	54.00
60.00	06000	LABORATORY	1,406	14,663	278,300	155	278,300	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,962	0	1,962	65.00
66.00	06600	PHYSICAL THERAPY	1,449	1,362	239,292	43	239,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	155,253	0	155,253	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,867	0	1,867	68.00
69.00	06900	ELECTROCARDIOLOGY	0	751	2,733	0	2,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484	6,014	125,693	20	125,693	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,192	7,002	406,848	182	406,848	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,251	8,833	401,402	214	401,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	44,197	90,929	117	90,929	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,087	307,656	5,171,233	2,019	5,052,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	395,133	341,645	1,402,900	64,462	121,435	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.802434	1.110477	0.271289	31.927687	0.024037	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	11,510	3,791	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	5.700842	0.000750	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	HOSPITAL BILLING (NON-NURSIN G HOME CHA)	NURSING HOME BILLING (NURSING HO ME 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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING	11,471,920					5.03
5.04	00513	NURSING HOME BILLING	0	1,791,142				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-1,310,543	10,162,141		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	612,979	41,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	61,385	1,332	8.00
9.00	00900	HOUSEKEEPING	0	0	0	252,461	556	9.00
10.00	01000	DIETARY	0	0	0	355,546	1,541	10.00
11.00	01100	CAFETERIA	0	0	0	4,034	593	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	164,795	787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	61,366	520	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	263,486	1,224	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	2,869	100	16.01
17.00	01700	SOCIAL SERVICE	0	0	0	85,784	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,341,587	0	0	1,674,545	9,360	30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,791,142	0	1,031,974	8,820	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	476,658	0	0	304,208	2,095	50.00
53.00	05300	ANESTHESIOLOGY	80,315	0	0	42,304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,633,757	0	0	501,638	1,393	54.00
60.00	06000	LABORATORY	1,828,972	0	0	676,165	1,406	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,229	0	0	27,798	0	65.00
66.00	06600	PHYSICAL THERAPY	907,508	0	0	355,405	1,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	504,196	0	0	225,591	495	67.00
68.00	06800	SPEECH PATHOLOGY	11,384	0	0	4,529	0	68.00
69.00	06900	ELECTROCARDIOLOGY	83,524	0	0	9,087	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	224,517	0	0	47,318	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,639	0	0	8,583	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,281,153	0	0	413,153	484	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,857,972	0	0	1,649,425	5,192	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	605,863	0	0	1,083,890	1,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	479,646	0	0	241,823	2,820	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,471,920	1,791,142	-1,310,543	10,162,141	41,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	436,227	740		1,310,543	692,031	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.038026	0.000413		0.128963	16.646965	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,524	639		44,846	80,925	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000917	0.000357		0.004413	1.946670	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						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	26,289					8.00
9.00	00900	HOUSEKEEPING	0	30,654				9.00
10.00	01000	DIETARY	0	165	45,447			10.00
11.00	01100	CAFETERIA	0	0	8,452	9,407		11.00
13.00	01300	NURSING ADMINISTRATION	0	358	0	177	119,038	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	520	0	1	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	557	0	476	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	100	0	5	0	16.01
17.00	01700	SOCIAL SERVICE	0	153	0	75	1,566	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,207	9,199	7,319	2,468	51,341	30.00
44.00	04400	SKILLED NURSING FACILITY	17,632	8,492	29,641	2,032	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	303	1,383	0	242	5,029	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	524	1,233	0	412	0	54.00
60.00	06000	LABORATORY	0	1,406	0	581	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	478	1,449	0	350	7,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	495	0	166	3,450	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2	33	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	406	0	177	3,673	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	312	3,487	0	942	19,593	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,639	1,251	0	1,044	21,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	194	0	0	257	5,348	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,289	30,654	45,412	9,407	119,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	35	0	0	194.02
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)	91,475	294,275	428,635	94,141	204,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.479592	9.599889	9.431536	10.007548	1.716729	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,011	6,348	16,713	8,314	8,009	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.456883	0.207086	0.367747	0.883810	0.067281	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/23/2013 9:51 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (# OF LOADS)	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CHA)	NURSING HOME MEDICAL RECORDS & LIBR (NURSING HO ME CHARGES)	SOCIAL SERVICE (TIME SPENT)		
			14.00	16.00	16.01	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	00510	PURCHASING						5.01
5.02	00511	PERSONNEL						5.02
5.03	00512	HOSPITAL BILLING						5.03
5.04	00513	NURSING HOME BILLING						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	1,089					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,471,920				16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	1,791,142			16.01
17.00	01700	SOCIAL SERVICE	0	0	0	3,190		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11	1,341,587	0	1,455		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,791,142	1,735		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	531	476,658	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	80,315	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,633,757	0	0		54.00
60.00	06000	LABORATORY	0	1,828,972	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	122,229	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	907,508	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	504,196	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	11,384	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	83,524	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	224,517	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,639	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,281,153	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	534	1,857,972	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	13	605,863	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	479,646	0	0		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,089	11,471,920	1,791,142	3,190		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	RENTAL HOUSE	0	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02
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)	82,938	327,953	5,914	104,302		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	76.159780	0.028587	0.003302	32.696552		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,223	15,682	929	1,975		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.632691	0.001367	0.000519	0.619122		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-2 | Date/Time Prepared: 10/23/2013 9:51 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		IV THERAPY	1	64.00	27,513	5.00
6.00		IV THERAPY	1	30.00	-14,758	6.00
7.00		IV THERAPY	1	73.00	-12,755	7.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,406,619		2,406,619	0	2,406,619	30.00
44.00	04400	SKILLED NURSING FACILITY	1,817,300		1,817,300	0	1,817,300	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	457,768		457,768	0	457,768	50.00
53.00	05300	ANESTHESIOLOGY	50,056		50,056	0	50,056	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,007		654,007	0	654,007	54.00
60.00	06000	LABORATORY	858,367		858,367	0	858,367	60.00
64.00	06400	INTRAVENOUS THERAPY	27,513		27,513	0	27,513	64.00
65.00	06500	RESPIRATORY THERAPY	34,877	0	34,877	0	34,877	65.00
66.00	06600	PHYSICAL THERAPY	482,892	0	482,892	0	482,892	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,673	0	289,673	0	289,673	67.00
68.00	06800	SPEECH PATHOLOGY	5,515	0	5,515	0	5,515	68.00
69.00	06900	ELECTROCARDIOLOGY	12,647		12,647	0	12,647	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,838		59,838	0	59,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,623		10,623	0	10,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,335		510,335	0	510,335	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,119,984		2,119,984	0	2,119,984	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	1,328,247		1,328,247	0	1,328,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,166		73,166		73,166	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	346,093		346,093	0	346,093	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,545,520	0	11,545,520	0	11,545,520	200.00
201.00		Less Observation Beds	73,166		73,166		73,166	201.00
202.00		Total (see instructions)	11,472,354	0	11,472,354	0	11,472,354	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,179,387		1,179,387			30.00
44.00	04400	SKILLED NURSING FACILITY	1,791,142		1,791,142			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578	471,080	476,658	0.960370	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	902	79,413	80,315	0.623246	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,820	1,575,937	1,633,757	0.400309	0.000000	54.00
60.00	06000	LABORATORY	171,960	1,657,012	1,828,972	0.469317	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	147,465	188,081	335,546	0.081995	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	97,155	25,074	122,229	0.285341	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	569,431	338,077	907,508	0.532108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,208	107,988	504,196	0.574525	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,355	3,029	11,384	0.484452	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,157	70,367	83,524	0.151418	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,144	66,374	224,518	0.266518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,639	32,639	0.325470	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,250	329,357	945,607	0.539690	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	104,790	1,753,182	1,857,972			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	819	605,044	605,863	2.192322	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	162,200	162,200	0.451085	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	479,646	479,646	0.721559	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,318,563	7,944,500	13,263,063			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,318,563	7,944,500	13,263,063			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,406,619		2,406,619	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	1,817,300		1,817,300	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	457,768		457,768	0	0	50.00
53.00	05300	ANESTHESIOLOGY	50,056		50,056	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	654,007		654,007	0	0	54.00
60.00	06000	LABORATORY	858,367		858,367	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	27,513		27,513	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,877	0	34,877	0	0	65.00
66.00	06600	PHYSICAL THERAPY	482,892	0	482,892	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	289,673	0	289,673	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,515	0	5,515	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,647		12,647	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,838		59,838	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,623		10,623	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,335		510,335	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,119,984		2,119,984	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	1,328,247		1,328,247	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	73,166		73,166		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	346,093		346,093	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,545,520	0	11,545,520	0	0	200.00
201.00		Less Observation Beds	73,166		73,166		0	201.00
202.00		Total (see instructions)	11,472,354	0	11,472,354	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,179,387		1,179,387			30.00
44.00	04400	SKILLED NURSING FACILITY	1,791,142		1,791,142			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578	471,080	476,658	0.960370	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	902	79,413	80,315	0.623246	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,820	1,575,937	1,633,757	0.400309	0.000000	54.00
60.00	06000	LABORATORY	171,960	1,657,012	1,828,972	0.469317	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	147,465	188,081	335,546	0.081995	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	97,155	25,074	122,229	0.285341	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	569,431	338,077	907,508	0.532108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	396,208	107,988	504,196	0.574525	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	8,355	3,029	11,384	0.484452	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,157	70,367	83,524	0.151418	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,144	66,374	224,518	0.266518	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,639	32,639	0.325470	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,250	329,357	945,607	0.539690	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	104,790	1,753,182	1,857,972	1.141020	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	819	605,044	605,863	2.192322	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	162,200	162,200	0.451085	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	479,646	479,646	0.721559	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,318,563	7,944,500	13,263,063			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,318,563	7,944,500	13,263,063			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/23/2013 9:51 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	162,879	476,658	0.341710	0	0	50.00
53.00	05300	ANESTHESIOLOGY	405	80,315	0.005043	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,393	1,633,757	0.070630	15,173	1,072	54.00
60.00	06000	LABORATORY	37,642	1,828,972	0.020581	36,713	756	60.00
64.00	06400	INTRAVENOUS THERAPY	0	335,546	0.000000	29	0	64.00
65.00	06500	RESPIRATORY THERAPY	21,030	122,229	0.172054	15,439	2,656	65.00
66.00	06600	PHYSICAL THERAPY	19,572	907,508	0.021567	5,160	111	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,076	504,196	0.014034	2,653	37	67.00
68.00	06800	SPEECH PATHOLOGY	51	11,384	0.004480	220	1	68.00
69.00	06900	ELECTROCARDIOLOGY	1,067	83,524	0.012775	8,842	113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,127	224,518	0.005020	17,985	90	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	227	32,639	0.006955	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,648	945,607	0.022893	65,056	1,489	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	89,098	1,857,972	0.047954	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	38,448	605,863	0.063460	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	162,200	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	515,663	9,812,888		167,270	6,325	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	476,658	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	80,315	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,633,757	0.000000	0.000000	15,173	54.00
60.00	06000	LABORATORY	0	1,828,972	0.000000	0.000000	36,713	60.00
64.00	06400	INTRAVENOUS THERAPY	0	335,546	0.000000	0.000000	29	64.00
65.00	06500	RESPIRATORY THERAPY	0	122,229	0.000000	0.000000	15,439	65.00
66.00	06600	PHYSICAL THERAPY	0	907,508	0.000000	0.000000	5,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	504,196	0.000000	0.000000	2,653	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,384	0.000000	0.000000	220	68.00
69.00	06900	ELECTROCARDIOLOGY	0	83,524	0.000000	0.000000	8,842	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	224,518	0.000000	0.000000	17,985	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,639	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	945,607	0.000000	0.000000	65,056	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,857,972	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	605,863	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	162,200	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	9,812,888			167,270	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.960370	0	261,231	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.623246	0	59,767	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.400309	0	422,654	0	0	54.00
60.00	06000	LABORATORY	0.469317	0	496,225	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.081995	0	72,354	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.285341	0	18,328	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.532108	0	158,321	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.574525	0	53,012	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.484452	0	1,755	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151418	0	32,711	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.266518	0	65,061	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325470	0	24,616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.539690	0	99,427	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	2.192322	0	163,969	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.451085	0	71,380	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.721559		0			95.00
200.00		Subtotal (see instructions)		0	2,000,811	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	2,000,811	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	250,878	0	50.00
53.00	05300	ANESTHESIOLOGY	37,250	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,192	0	54.00
60.00	06000	LABORATORY	232,887	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,933	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,230	0	65.00
66.00	06600	PHYSICAL THERAPY	84,244	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,457	0	67.00
68.00	06800	SPEECH PATHOLOGY	850	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,953	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,340	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,012	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,660	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	359,473	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,198	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,292,557	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,292,557	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.960370	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.623246	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.400309	0	0	0	0	54.00
60.00	06000	LABORATORY	0.469317	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.081995	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.285341	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.532108	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.574525	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.484452	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151418	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.266518	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325470	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.539690	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	2.192322	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.451085	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.721559		0			95.00
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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 141329 | Component CCN: 145274 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141329 | Component CCN: 145274 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	476,658	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	80,315	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,633,757	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	1,828,972	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	335,546	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	122,229	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	907,508	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	504,196	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,384	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	83,524	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	224,518	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,639	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	945,607	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,857,972	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	605,863	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	162,200	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	9,812,888			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,508	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	246	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)	177	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	996	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)	996	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	135	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)	135	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	123	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)	904	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)	903	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	122.21	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	125.88	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,406,619	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)	16,498	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)	16,994	25.00
26.00	Total swing-bed cost (see instructions)	2,145,769	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	260,850	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	385,258	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	385,258	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.677079	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)	2,176.60	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)	260,850	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,060.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	130,427	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)	130,427	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	73,330	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	203,757	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)	958,584	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	957,523	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,916,107	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)	69	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,060.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	73,166	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 10/23/2013 9:51 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,990	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,990	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)	9,990	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)	0	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)	1,817,300	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,817,300	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,717,232	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,717,232	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.058273	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)	171.90	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,817,300	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: 141329 | Period: From 07/01/2012 | Worksheet D-1
Component CCN: 145274 | To 06/30/2013 | Date/Time Prepared: 10/23/2013 9:51 am
Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,817,300	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	181.91	71.00
72.00	Program routine service cost (line 9 x line 71)	0	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)	0	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)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	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)	0	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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1

Component CCN: 145274 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		117,043		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.960370	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.623246	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.400309	15,173	6,074	54.00
60.00	06000	LABORATORY	0.469317	36,713	17,230	60.00
64.00	06400	INTRAVENOUS THERAPY	0.081995	29	2	64.00
65.00	06500	RESPIRATORY THERAPY	0.285341	15,439	4,405	65.00
66.00	06600	PHYSICAL THERAPY	0.532108	5,160	2,746	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.574525	2,653	1,524	67.00
68.00	06800	SPEECH PATHOLOGY	0.484452	220	107	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151418	8,842	1,339	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.266518	17,985	4,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325470	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.539690	65,056	35,110	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	2.192322	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.451085	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		167,270	73,330	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)		167,270		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3

Component CCN: 14Z329 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.960370	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.623246	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.400309	37,450	14,992	54.00
60.00	06000	LABORATORY	0.469317	104,806	49,187	60.00
64.00	06400	INTRAVENOUS THERAPY	0.081995	142,358	11,673	64.00
65.00	06500	RESPIRATORY THERAPY	0.285341	65,049	18,561	65.00
66.00	06600	PHYSICAL THERAPY	0.532108	492,592	262,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.574525	345,188	198,319	67.00
68.00	06800	SPEECH PATHOLOGY	0.484452	8,135	3,941	68.00
69.00	06900	ELECTROCARDIOLOGY	0.151418	3,471	526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.266518	114,924	30,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325470	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.539690	337,122	181,941	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	2.192322	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.451085	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,651,095	771,881	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,651,095		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part B Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,292,557	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,292,557	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,305,483	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)	7,810	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	300,407	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)	997,266	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)	997,266	30.00
31.00	Primary payer payments	413	31.00
32.00	Subtotal (line 30 minus line 31)	996,853	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)	47,842	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	47,842	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,640	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,044,695	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	SEQUESTRATION	-4,024	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,040,671	40.00
41.00	Interim payments	947,476	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)	93,195	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		125,782		909,309	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/03/2013	2,156	04/22/2013	69,142	3.01
3.02		04/22/2013	41,585		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	01/03/2013	30,975	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)		43,741		38,167	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)		169,523		947,476	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		9,613		93,195	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		179,136		1,040,671	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/23/2013 9:51 am

Component CCN: 14Z329 | 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		2,140,152		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/03/2013	45,075		0	3.01
3.02		04/22/2013	500,801		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)		545,876		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)		2,686,028		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,675		0	6.02
7.00	Total Medicare program liability (see instructions)		2,659,353		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-2 | Date/Time Prepared: 10/23/2013 9:51 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,935,268	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)	779,600	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,807	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)	2,714,868	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,714,868	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)	2,714,868	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	64,690	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)	2,650,178	0	15.00
16.00	SEQUESTRATION	-12,051	0	16.00
17.00	Reimbursable bad debts (see instructions)	21,226	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	21,226	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,659,353	0	19.00
20.00	Interim payments	2,686,028	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-26,675	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: 141329	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 10/23/2013 9:51 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	203,757	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)	203,757	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	205,795	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)	205,795	19.00
20.00	Deductibles (exclude professional component)	34,766	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	171,029	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	171,029	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,641	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	8,641	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,780	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	179,670	28.00
29.00	SEQUESTRATION	-534	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	179,136	30.00
31.00	Interim payments	169,523	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)	9,613	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: 141329 Component CCN: 145274	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 10/23/2013 9:51 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	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)	0	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	0	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)	0	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	0	15.00
16.00	Interim payments	0	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)	0	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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 10/23/2013 9:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	948,313	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,956,615	0	0	0	4.00
5.00	Other receivable	1,190,219	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	156,629	0	0	0	7.00
8.00	Prepaid expenses	139,591	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,391,367	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	563,489	0	0	0	13.00
14.00	Accumulated depreciation	-295,020	0	0	0	14.00
15.00	Buildings	7,774,792	0	0	0	15.00
16.00	Accumulated depreciation	-4,582,568	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	-325,876	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	4,261,832	0	0	0	23.00
24.00	Accumulated depreciation	-3,028,126	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)	4,390,180	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	391,559	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	391,559	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,173,106	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	611,580	0	0	0	37.00
38.00	Salaries, wages, and fees payable	324,347	0	0	0	38.00
39.00	Payroll taxes payable	83,483	0	0	0	39.00
40.00	Notes and loans payable (short term)	194,129	0	0	0	40.00
41.00	Deferred income	474,000	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	79,086	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,766,625	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,140,965	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,140,965	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,907,590	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,265,516				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)	4,265,516	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,173,106	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 10/23/2013 9:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,836,872		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-571,356				2.00
3.00	Total (sum of line 1 and line 2)		4,265,516		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)		4,265,516		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)		4,265,516		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: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/23/2013 9:51 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	385,258		385,258	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,007,686		1,007,686	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,791,142		1,791,142	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,184,086		3,184,086	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)	3,184,086		3,184,086	17.00
18.00	Ancillary services	2,176,819	5,284,592	7,461,411	18.00
19.00	Outpatient services	1,130	901,040	902,170	19.00
20.00	RURAL HEALTH CLINIC	0	1,843,959	1,843,959	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	479,646	479,646	23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,362,035	8,509,237	13,871,272	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,856,704		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		11,856,704		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 10/23/2013 9:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,871,272	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,954,812	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,916,460	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,856,704	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-940,244	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	50	6.00
7.00	Income from investments	13,832	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	21,290	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	4,712	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	236,541	24.00
24.01	COUNTY TAX REVENUE	902,297	24.01
24.02	STATE TAX REVENUE	84,993	24.02
25.00	Total other income (sum of lines 6-24)	1,263,715	25.00
26.00	Total (line 5 plus line 25)	323,471	26.00
27.00	BAD DEBTS	865,454	27.00
27.01	CHARITY CARE	29,373	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	894,827	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-571,356	29.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 10/23/2013 9:51 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	84,643	0	84,643	0	84,643	1.00
2.00	Physician Assistant	5,324	0	5,324	0	5,324	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	316,881	0	316,881	0	316,881	9.00
10.00	Subtotal (sum of lines 1-9)	406,848	0	406,848	0	406,848	10.00
11.00	Physician Services Under Agreement	0	725,447	725,447	0	725,447	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	195,104	195,104	0	195,104	13.00
14.00	Subtotal (sum of lines 11-13)	0	920,551	920,551	0	920,551	14.00
15.00	Medical Supplies	0	80,310	80,310	0	80,310	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	176,812	176,812	-176,812	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	257,122	257,122	-176,812	80,310	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	406,848	1,177,673	1,584,521	-176,812	1,407,709	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,500	17,500	0	17,500	29.00
30.00	Administrative Costs	0	37,195	37,195	0	37,195	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	54,695	54,695	0	54,695	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	406,848	1,232,368	1,639,216	-176,812	1,462,404	32.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 10/23/2013 9:51 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	84,643		1.00
2.00	Physician Assistant	-1,224	4,100		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-22,719	294,162		9.00
10.00	Subtotal (sum of lines 1-9)	-23,943	382,905		10.00
11.00	Physician Services Under Agreement	0	725,447		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	195,104		13.00
14.00	Subtotal (sum of lines 11-13)	0	920,551		14.00
15.00	Medical Supplies	0	80,310		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	80,310		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-23,943	1,383,766		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	17,500		29.00
30.00	Administrative Costs	-28,741	8,454		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-28,741	25,954		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-52,684	1,409,720		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141329 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-2

Component CCN: 143981 | Date/Time Prepared: 10/23/2013 9:51 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.54	9,926	4,200	6,468		1.00
2.00	Physician Assistant	1.21	3,969	2,100	2,541		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	2.75	13,895		9,009	13,895	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.75	13,895			13,895	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,383,766	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,383,766	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					25,954	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					710,264	15.00
16.00	Total overhead (sum of lines 14 and 15)					736,218	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					736,218	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					736,218	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,119,984	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-3 | Date/Time Prepared: 10/23/2013 9:51 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,119,984	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,071	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,110,913	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		13,895	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,895	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		151.92	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	151.92	151.92	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,370	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	208,130	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		208,130	16.00
16.01	Total program charges (see instructions)(from contractor's records)		170,260	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		455	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		556	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		151,042	16.04
16.05	Total program cost (see instructions)		151,598	16.05
17.00	Primary payer amounts		87	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,771	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		30,207	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		151,511	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,744	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		153,255	22.00
23.00	Reimbursable bad debts (see instructions)		16,981	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		16,620	24.00
25.00	SEQUESTRATION		-501	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		169,735	26.00
27.00	Interim payments		113,260	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		56,475	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2012 To 06/30/2013	Worksheet M-4 Date/Time Prepared: 10/23/2013 9:51 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	382,905	382,905	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000474	0.002370	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	181	907	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,564	3,269	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,745	4,176	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,383,766	1,383,766	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	736,218	736,218	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001261	0.003018	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	928	2,222	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,673	6,398	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	29	145	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	92.17	44.12	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	27	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	553	1,191	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		9,071	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,744	16.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-5 | Date/Time Prepared: 10/23/2013 9:51 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		99,039	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		01/03/2013	5,169	3.01
3.02		04/22/2013	9,052	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		14,221	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		113,260	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		56,475	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		169,735	7.00

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