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: 141349	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 10/28/2013 10:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/28/2013 Time: 10:34 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 SPARTA COMMUNITY HOSPITAL (141349) 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	237,566	59,286	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	75,896	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		101,718		0	10.00
200.00	Total	0	313,462	161,004	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2013 10:33 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 818 EAST BROADWAY	PO Box:			1.00
2.00	City: SPARTA	State: IL	Zip Code: 62286	County: RANDOLPH	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	SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	3	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 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2013 10:33 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.	N			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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2013 10:33 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)	N	N	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2013 10:33 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	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)	N	N	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	530,987	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

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							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						1	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2013 10:33 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	N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/16/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2013 10:33 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	STLOUISHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2013 10:33 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)	08/16/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR		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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/28/2013 10:33 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	39,960.00	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	39,960.00	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	39,960.00	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/28/2013 10:33 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)	1,128	141	1,665			1.00
2.00	HMO	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	780	0	849			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	51			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,908	141	2,565			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)	1,908	141	2,565	0.00	178.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,333	0	5,888	0.00	8.72	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	10,840	0	42,252	0.00	50.81	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	238.30	27.00
28.00	Observation Bed Days		74	508			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			15			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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 10/28/2013 10:33 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	367	59	577	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	367	59	577	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141349 | Component CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-4 | Date/Time Prepared: 10/28/2013 10:33 am

Home Health Agency I | PPS

		1.00	
0.00	County	RANDOLPH	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	8	0	2	10	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	236.00	28.00	57.00	321.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.21	0.00	2.21	5.00
6.00	Direct Nursing Service		4.89	0.00	4.89	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.59	0.08	1.67	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.19	0.19	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.07	0.07	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.03	0.00	0.03	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			41180			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,035	158	38	46	2,277	21.00
22.00	Skilled Nursing Visit Charges	466,492	35,334	9,403	10,610	521,839	22.00
23.00	Physical Therapy Visits	1,780	18	13	20	1,831	23.00
24.00	Physical Therapy Visit Charges	333,351	3,358	3,190	3,623	343,522	24.00
25.00	Occupational Therapy Visits	120	17	0	0	137	25.00
26.00	Occupational Therapy Visit Charges	24,193	3,257	0	0	27,450	26.00
27.00	Speech Pathology Visits	56	19	0	0	75	27.00
28.00	Speech Pathology Visit Charges	12,978	4,403	0	0	17,381	28.00
29.00	Medical Social Service Visits	5	0	0	0	5	29.00
30.00	Medical Social Service Visit Charges	1,669	0	0	0	1,669	30.00
31.00	Home Health Aide Visits	7	1	0	0	8	31.00
32.00	Home Health Aide Visit Charges	687	337	0	0	1,024	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,003	213	51	66	4,333	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	839,370	46,689	12,593	14,233	912,885	35.00
36.00	Total Number of Episodes (standard/non outlier)	242		17	6	265	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	25,320	4,337	198	270	30,125	38.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 10/28/2013 10:33 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1300 NORTH MARKET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	SPARTA		IL	62286	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	13:00	17:00	11:30	19:00	11:30	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.			Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	WOMENS HEALTH CLINIC	143464	14.00
14.01		COULTERVILLE MEDICAL CLINIC	143465	14.01
14.02		FAMILY HEALTH CLINIC	143466	14.02
14.03		STEELEVILLE CLINIC	143467	14.03
14.04		MARISSA MEDICAL CLINIC	143490	14.04
14.05		SPARTA MEDICAL OFFICE	143489	14.05

		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)	N	0	0	0	0	15.00

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

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

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 10/28/2013 10:33 am

Rural Health Clinic (RHC) I | Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	13:00	19:00	11:30	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	11:30	19:00	10:00	15:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 10/28/2013 10:33 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)	0.452195	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,493,130	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,503,817	5.00
6.00	Medicaid charges	7,323,367	6.00
7.00	Medicaid cost (line 1 times line 6)	3,311,590	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)	314,643	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)	314,643	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	282,357	0	282,357	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	127,680	0	127,680	21.00
22.00	Partial payment by patients approved for charity care	14,410	0	14,410	22.00
23.00	Cost of charity care (line 21 minus line 22)	113,270	0	113,270	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,680,164	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	474,978	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	2,205,186	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	997,174	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,110,444	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,425,087	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/28/2013 10:33 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		805,515	805,515	-15,333	790,182	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	211,954	211,954	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		909,934	909,934	20,600	930,534	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	3,463,949	3,463,949	0	3,463,949	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,969,854	2,018,146	3,988,000	437,278	4,425,278	5.00
6.00	00600	MAINTENANCE & REPAIRS	178,596	6,248	184,844	0	184,844	6.00
7.00	00700	OPERATION OF PLANT	0	417,538	417,538	0	417,538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,091	43,091	0	43,091	8.00
9.00	00900	HOUSEKEEPING	260,445	36,555	297,000	0	297,000	9.00
10.00	01000	DIETARY	218,079	127,524	345,603	0	345,603	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	85,721	14,699	100,420	0	100,420	13.00
15.00	01500	PHARMACY	0	888,455	888,455	0	888,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,375	50,609	197,984	0	197,984	16.00
17.00	01700	SOCIAL SERVICE	36,561	558	37,119	0	37,119	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	557,030	557,030	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,047,358	333,335	1,380,693	0	1,380,693	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	516,348	787,638	1,303,986	-546,914	757,072	50.00
53.00	05300	ANESTHESIOLOGY	241,030	369,643	610,673	-557,030	53,643	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	362,883	111,784	474,667	-71,427	403,240	54.00
54.01	05401	ULTRASOUND	80,703	38,438	119,141	555	119,696	54.01
56.00	05600	RADIOISOTOPE	0	388,109	388,109	10,013	398,122	56.00
57.00	05700	CT SCAN	0	303,082	303,082	71,427	374,509	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	297,118	297,118	0	297,118	58.00
60.00	06000	LABORATORY	514,853	907,153	1,422,006	-15,034	1,406,972	60.00
65.00	06500	RESPIRATORY THERAPY	48,694	31,437	80,131	0	80,131	65.00
66.00	06600	PHYSICAL THERAPY	465,480	54,010	519,490	-1,044	518,446	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	19,130	4,505	23,635	4,466	28,101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	261,248	261,248	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	285,666	285,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	137,581	137,581	0	137,581	75.01
75.02	03952	WOUND CENTER	0	155,292	155,292	0	155,292	75.02
76.00	03953	CARDIAC REHAB	71,666	6,066	77,732	0	77,732	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,123,510	1,278,791	4,402,301	-256,547	4,145,754	88.00
91.00	09100	EMERGENCY	674,589	1,087,954	1,762,543	0	1,762,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	468,583	145,723	614,306	-248	614,058	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		164,395	164,395	-164,395	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,531,458	15,384,875	25,916,333	232,265	26,148,598	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,778	5,778	0	5,778	192.00
194.00	07950	FREESTANDING CLINICS	946,428	94,322	1,040,750	-232,265	808,485	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	11,477,886	15,484,975	26,962,861	0	26,962,861	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 10/28/2013 10:33 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	-44,334	745,848		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	211,954		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-143,042	787,492		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-599,279	2,864,670		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-281,267	4,144,011		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	184,844		6.00
7.00	00700	OPERATION OF PLANT	0	417,538		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,091		8.00
9.00	00900	HOUSEKEEPING	0	297,000		9.00
10.00	01000	DIETARY	-41,438	304,165		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	100,420		13.00
15.00	01500	PHARMACY	0	888,455		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,705	170,279		16.00
17.00	01700	SOCIAL SERVICE	0	37,119		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-557,030	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-167,501	1,213,192		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	757,072		50.00
53.00	05300	ANESTHESIOLOGY	0	53,643		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-1,139	402,101		54.00
54.01	05401	ULTRASOUND	0	119,696		54.01
56.00	05600	RADIOISOTOPE	0	398,122		56.00
57.00	05700	CT SCAN	0	374,509		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	297,118		58.00
60.00	06000	LABORATORY	0	1,406,972		60.00
65.00	06500	RESPIRATORY THERAPY	0	80,131		65.00
66.00	06600	PHYSICAL THERAPY	0	518,446		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	28,101		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	261,248		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	285,666		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	137,581		75.01
75.02	03952	WOUND CENTER	0	155,292		75.02
76.00	03953	CARDIAC REHAB	0	77,732		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,145,754		88.00
91.00	09100	EMERGENCY	-759,683	1,002,860		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	614,058		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,622,418	23,526,180		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,778		192.00
194.00	07950	FREESTANDING CLINICS	0	808,485		194.00
194.01	07951	UNUSED SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,622,418	24,340,443		200.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/28/2013 10:33 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS COST OF SUPPLIES SOLD				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	261,248	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	285,666	2.00
	TOTALS		0	546,914	
	B - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	163,796	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	599	2.00
	TOTALS		0	164,395	
	C - TO RECLASS EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	15,034	0	1.00
	TOTALS		15,034	0	
	D - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP RELATED COST	3.00	0	53,425	1.00
	TOTALS		0	53,425	
	E - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,754	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	35,754	
	F - TO RECLASS ADMINISTRATIVE EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	372,667	92,937	1.00
2.00	FREESTANDING CLINICS	194.00	0	141,645	2.00
	TOTALS		372,667	234,582	
	G - TO RECLASS CRNA SALARIES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	241,030	316,000	1.00
	TOTALS		241,030	316,000	
	H - TO RECLASS CT SCAN SALARIES				
1.00	CT SCAN	57.00	71,427	0	1.00
	TOTALS		71,427	0	
	I - TO RECLASS NORTH CAMPUS BUILDING				
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	205,489	1.00
	TOTALS		0	205,489	
	J - TO RECLASS RHC RECRUITMENT EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	11,254	1.00
	TOTALS		0	11,254	
	K - TO RECLASS EKG SALARIES				
1.00	RADIOISOTOPE	56.00	10,013	0	1.00
2.00	ULTRASOUND	54.01	555	0	2.00
	TOTALS		10,568	0	
500.00	Grand Total: Increases		710,726	1,567,813	500.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 10/28/2013 10:33 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES SOLD						
1.00	OPERATING ROOM	50.00	0	546,914	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	546,914			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	164,395	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	164,395			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	15,034	0	0		1.00
	TOTALS		15,034	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	53,425	12		1.00
	TOTALS		0	53,425			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	1,044	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	33,219	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	248	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	1,243	0		4.00
	TOTALS		0	35,754			
	F - TO RECLASS ADMINISTRATIVE EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	234,582	0		1.00
2.00	FREESTANDING CLINICS	194.00	372,667	0	0		2.00
	TOTALS		372,667	234,582			
	G - TO RECLASS CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	241,030	316,000	0		1.00
	TOTALS		241,030	316,000			
	H - TO RECLASS CT SCAN SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	71,427	0	0		1.00
	TOTALS		71,427	0			
	I - TO RECLASS NORTH CAMPUS BUILDING						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	205,489	9		1.00
	TOTALS		0	205,489			
	J - TO RECLASS RHC RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,254	0		1.00
	TOTALS		0	11,254			
	K - TO RECLASS EKG SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	10,568	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		10,568	0			
500.00	Grand Total: Decreases		710,726	1,567,813			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 10/28/2013 10:33 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	179,834	0	0	0	0	1.00
2.00	Land Improvements	778,902	9,999	0	9,999	41,984	2.00
3.00	Buildings and Fixtures	15,642,640	149,379	0	149,379	309,103	3.00
4.00	Building Improvements	23,103	0	0	0	1,007	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,622,396	640,614	0	640,614	1,384,774	6.00
7.00	HIT designated Assets	433,521	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,680,396	799,992	0	799,992	1,736,868	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,680,396	799,992	0	799,992	1,736,868	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	179,834	0	1.00
2.00	Land Improvements	746,917	0	2.00
3.00	Buildings and Fixtures	15,482,916	0	3.00
4.00	Building Improvements	22,096	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,878,236	0	6.00
7.00	HIT designated Assets	433,521	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,743,520	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	26,743,520	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 10/28/2013 10:33 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	805,515	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	909,934	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,715,449	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	805,515	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	909,934	2.00
3.00	Total (sum of lines 1-2)	0	1,715,449	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III | Date/Time Prepared: 10/28/2013 10:33 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	13,195,687	0	13,195,687	0.493416	26,360	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,236,076	0	3,236,076	0.121004	6,465	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	10,311,757	0	10,311,757	0.385580	20,600	2.00
3.00	Total (sum of lines 1-2)	26,743,520	0	26,743,520	1.000000	53,425	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	26,360	600,026	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	6,465	205,489	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,600	766,892	0	2.00
3.00	Total (sum of lines 1-2)	0	0	53,425	1,572,407	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	119,462	26,360	0	0	745,848	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	6,465	0	0	211,954	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,600	0	0	787,492	2.00
3.00	Total (sum of lines 1-2)	119,462	53,425	0	0	1,745,294	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/28/2013 10:33 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	-44,334	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-160	ADMINISTRATIVE & GENERAL	5.00	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)	B	-27,265	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-928,323			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	-41,438	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	B	-13	ADMINISTRATIVE & GENERAL	5.00	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	-27,705	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
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-557,030	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 10/28/2013 10:33 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-142,762	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-9,185	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-42,785	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-4,371	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	PERSONAL USE OF AUTO	A	-22,169	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-28,919	EMPLOYEE BENEFITS	4.00	0	33.05
33.06	MARKETING SALARY	A	-34,242	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-100,671	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-18,321	EMPLOYEE BENEFITS	4.00	0	33.08
33.09	MARKETING CAPITAL EXPENSE	A	-280	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	LOBBYING EXPENSES	A	-11,805	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SELF INSURANCE EXPENSE	A	-493,291	EMPLOYEE BENEFITS	4.00	0	33.11
33.12	SELF INSURANCE EXPENS RHC	A	-58,748	EMPLOYEE BENEFITS	4.00	0	33.12
33.14	VOLUNTARY HOSPITAL CONTRIBUTION	A	-16,467	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PHYSICIAN RECRUITMENT	A	-12,000	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ALCOHOLIC BEVERAGES	A	-134	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,622,418				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 10/28/2013 10:33 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	30.00	ADULTS & PEDIATRICS	170,501	167,501	3,000	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	24,000	0	24,000	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	1,139	1,139	0	0	0	3.00
4.00	60.00	LABORATORY	20,600	0	20,600	0	0	4.00
5.00	91.00	EMERGENCY	953,770	759,683	194,087	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,170,010	928,323	241,687		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	167,501		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	1,139		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	759,683		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	928,323		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/28/2013 10:33 am

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	2	1.00
2.00	Line 1 multiplied by 15 hours per week	30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	2	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	5.85	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2.75	5.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	95.18	70.50	52.88	35.25	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)	35.25	35.25	26.44			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)	194	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	291	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	485	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)	485	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)	58.79	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	1,764	22.00
23.00	Total salary equivalency (see instructions)	1,764	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)	71	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)	71	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)	12	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	83	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)	121	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/28/2013 10:33 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
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)	70.50	52.88	35.25	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)	1,764	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	121	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)	1,885	63.00
64.00	Total cost of outside supplier services (from your records)	413	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	71	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	12	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	83	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	12	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	12	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/28/2013 10:33 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					3	1.00
2.00	Line 1 multiplied by 15 hours per week					45	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3	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					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	128.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	91.45	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)					8,671	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)					8,671	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)					8,671	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					8,671	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)					102	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)					102	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)					18	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					120	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)					121	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/28/2013 10:33 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)	8,671	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	121	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)	8,792	63.00
64.00	Total cost of outside supplier services (from your records)	7,710	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	102	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	18	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	120	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	18	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	18	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	745,848	745,848				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	211,954	0	211,954			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	787,492			787,492		2.00
4.00	00400	EMPLOYEE BENEFITS	2,864,670	0	0	0	2,864,670	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,144,011	71,432	42,921	126,328	590,259	5.00
6.00	00600	MAINTENANCE & REPAIRS	184,844	35,828	0	624	45,669	6.00
7.00	00700	OPERATION OF PLANT	417,538	61,068	5,860	57,368	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,091	5,636	0	0	0	8.00
9.00	00900	HOUSEKEEPING	297,000	7,658	0	0	66,599	9.00
10.00	01000	DIETARY	304,165	17,625	0	8,342	55,766	10.00
11.00	01100	CAFETERIA	0	9,797	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	100,420	3,283	0	271	21,920	13.00
15.00	01500	PHARMACY	888,455	4,941	0	2,012	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	170,279	17,775	10,674	4,590	37,686	16.00
17.00	01700	SOCIAL SERVICE	37,119	0	0	0	9,349	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,213,192	71,154	0	50,036	267,824	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	757,072	66,427	0	141,512	132,037	50.00
53.00	05300	ANESTHESIOLOGY	53,643	941	0	1,262	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	402,101	14,246	0	199,576	74,529	54.00
54.01	05401	ULTRASOUND	119,696	3,840	0	3,278	20,779	54.01
56.00	05600	RADIOISOTOPE	398,122	3,080	0	0	2,560	56.00
57.00	05700	CT SCAN	374,509	3,872	0	250	18,265	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	297,118	0	0	0	0	58.00
60.00	06000	LABORATORY	1,406,972	19,240	0	42,418	127,811	60.00
65.00	06500	RESPIRATORY THERAPY	80,131	2,449	0	5,506	12,452	65.00
66.00	06600	PHYSICAL THERAPY	518,446	5,144	88,532	20,925	119,030	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	28,101	1,861	0	1,408	6,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	261,248	6,107	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	285,666	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	137,581	6,075	0	1,350	0	75.01
75.02	03952	WOUND CENTER	155,292	15,882	0	0	0	75.02
76.00	03953	CARDIAC REHAB	77,732	9,615	0	8,443	18,326	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,145,754	150,586	63,967	52,668	798,731	88.00
91.00	09100	EMERGENCY	1,002,860	31,892	0	25,604	172,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	614,058	17,550	0	8,086	119,823	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,526,180	665,004	211,954	761,857	2,717,951	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,139	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	808,485	78,705	0	25,635	146,719	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	24,340,443	745,848	211,954	787,492	2,864,670	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,974,951	4,974,951				5.00
6.00	00600	MAINTENANCE & REPAIRS	266,965	68,583	335,548			6.00
7.00	00700	OPERATION OF PLANT	541,834	139,196	30,628	711,658		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,727	12,518	2,827	13,143	77,215	8.00
9.00	00900	HOUSEKEEPING	371,257	95,375	3,841	17,857	0	9.00
10.00	01000	DIETARY	385,898	99,136	8,840	41,101	101	10.00
11.00	01100	CAFETERIA	9,797	2,517	4,913	22,845	0	11.00
13.00	01300	NURSING ADMINISTRATION	125,894	32,342	1,647	7,657	0	13.00
15.00	01500	PHARMACY	895,408	230,029	2,478	11,522	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,004	61,913	8,915	41,450	0	16.00
17.00	01700	SOCIAL SERVICE	46,468	11,938	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,206	411,604	35,686	165,923	27,785	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,097,048	281,829	33,316	154,901	15,559	50.00
53.00	05300	ANESTHESIOLOGY	55,846	14,347	472	2,195	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	690,452	177,376	7,145	33,220	5,378	54.00
54.01	05401	ULTRASOUND	147,593	37,916	1,926	8,953	1,063	54.01
56.00	05600	RADIOISOTOPE	403,762	103,726	1,545	7,183	127	56.00
57.00	05700	CT SCAN	396,896	101,962	1,942	9,028	1,234	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	297,118	76,329	0	0	234	58.00
60.00	06000	LABORATORY	1,596,441	410,123	9,650	44,867	0	60.00
65.00	06500	RESPIRATORY THERAPY	100,538	25,828	1,228	5,711	0	65.00
66.00	06600	PHYSICAL THERAPY	752,077	193,207	2,580	11,996	10,567	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	37,404	9,609	933	4,340	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,355	68,683	3,063	14,241	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	285,666	73,387	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	145,006	37,252	3,047	14,166	0	75.01
75.02	03952	WOUND CENTER	171,174	43,974	7,965	0	0	75.02
76.00	03953	CARDIAC REHAB	114,116	29,316	4,822	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,211,706	1,338,870	90,796	0	930	88.00
91.00	09100	EMERGENCY	1,232,858	316,719	15,995	74,371	14,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	759,517	195,118	8,802	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,272,982	4,700,722	295,002	706,670	77,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,139	550	1,073	4,988	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	1,484	0	0	25	192.00
194.00	07950	FREESTANDING CLINICS	1,059,544	272,195	39,473	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	24,340,443	4,974,951	335,548	711,658	77,215	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	488,330					9.00
10.00	01000	DIETARY	5,745	540,821				10.00
11.00	01100	CAFETERIA	13,385	398,806	452,263			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,750	173,290		13.00
15.00	01500	PHARMACY	2,658	0	0	0	1,142,095	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,047	0	28,608	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	5,319	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,554	142,015	132,114	88,977	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,568	0	44,565	33,034	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	10,941	0	30,333	0	0	54.00
54.01	05401	ULTRASOUND	6,838	0	6,469	0	0	54.01
56.00	05600	RADIOISOTOPE	1,715	0	1,294	0	0	56.00
57.00	05700	CT SCAN	0	0	8,482	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	13,119	0	56,928	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,463	3,603	0	65.00
66.00	06600	PHYSICAL THERAPY	25,587	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,142,095	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	4,437	0	0	0	0	75.01
75.02	03952	WOUND CENTER	86	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	13,188	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	113,058	0	29,758	0	0	88.00
91.00	09100	EMERGENCY	55,543	0	72,310	47,676	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,419	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)	467,888	540,821	427,393	173,290	1,142,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	20,442	0	24,870	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	488,330	540,821	452,263	173,290	1,142,095	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	393,937					16.00
17.00	01700	SOCIAL SERVICE	0	63,725				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,485	63,725	0	2,837,074	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,131	0	0	1,759,951	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	72,860	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	80,540	0	0	1,035,385	0	54.00
54.01	05401	ULTRASOUND	19,227	0	0	229,985	0	54.01
56.00	05600	RADIOISOTOPE	3,418	0	0	522,770	0	56.00
57.00	05700	CT SCAN	22,431	0	0	541,975	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,409	0	0	380,090	0	58.00
60.00	06000	LABORATORY	59,603	0	0	2,190,731	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	142,371	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	996,014	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	52,286	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	353,342	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	359,053	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,142,095	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	203,908	0	75.01
75.02	03952	WOUND CENTER	0	0	0	223,199	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	161,442	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	63,876	0	0	6,848,994	0	88.00
91.00	09100	EMERGENCY	59,817	0	0	1,889,501	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	964,856	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	393,937	63,725	0	22,907,882	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	8,750	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,287	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0	0	1,416,524	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	393,937	63,725	0	24,340,443	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,837,074		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,759,951		50.00
53.00	05300	ANESTHESIOLOGY	72,860		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,035,385		54.00
54.01	05401	ULTRASOUND	229,985		54.01
56.00	05600	RADIOISOTOPE	522,770		56.00
57.00	05700	CT SCAN	541,975		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	380,090		58.00
60.00	06000	LABORATORY	2,190,731		60.00
65.00	06500	RESPIRATORY THERAPY	142,371		65.00
66.00	06600	PHYSICAL THERAPY	996,014		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	52,286		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	353,342		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	359,053		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,095		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	203,908		75.01
75.02	03952	WOUND CENTER	223,199		75.02
76.00	03953	CARDIAC REHAB	161,442		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	6,848,994		88.00
91.00	09100	EMERGENCY	1,889,501		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	964,856		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,907,882		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,750		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,287		192.00
194.00	07950	FREESTANDING CLINICS	1,416,524		194.00
194.01	07951	UNUSED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	24,340,443		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	79,958	71,432	42,921	126,328	320,639	5.00
6.00	00600	MAINTENANCE & REPAIRS	218	35,828	0	624	36,670	6.00
7.00	00700	OPERATION OF PLANT	0	61,068	5,860	57,368	124,296	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,636	0	0	5,636	8.00
9.00	00900	HOUSEKEEPING	0	7,658	0	0	7,658	9.00
10.00	01000	DIETARY	0	17,625	0	8,342	25,967	10.00
11.00	01100	CAFETERIA	0	9,797	0	0	9,797	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,283	0	271	3,554	13.00
15.00	01500	PHARMACY	6,829	4,941	0	2,012	13,782	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,775	10,674	4,590	33,039	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,067	71,154	0	50,036	154,257	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,618	66,427	0	141,512	260,557	50.00
53.00	05300	ANESTHESIOLOGY	0	941	0	1,262	2,203	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	37	14,246	0	199,576	213,859	54.00
54.01	05401	ULTRASOUND	0	3,840	0	3,278	7,118	54.01
56.00	05600	RADIOISOTOPE	0	3,080	0	0	3,080	56.00
57.00	05700	CT SCAN	139,336	3,872	0	250	143,458	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	19,240	0	42,418	61,658	60.00
65.00	06500	RESPIRATORY THERAPY	16,540	2,449	0	5,506	24,495	65.00
66.00	06600	PHYSICAL THERAPY	0	5,144	88,532	20,925	114,601	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	1,861	0	1,408	3,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,107	0	0	6,107	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	6,075	0	1,350	7,425	75.01
75.02	03952	WOUND CENTER	0	15,882	0	0	15,882	75.02
76.00	03953	CARDIAC REHAB	0	9,615	0	8,443	18,058	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,279	150,586	63,967	52,668	280,500	88.00
91.00	09100	EMERGENCY	-293	31,892	0	25,604	57,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	17,550	0	8,086	25,636	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	341,589	665,004	211,954	761,857	1,980,404	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,139	0	0	2,139	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49	0	0	0	49	192.00
194.00	07950	FREESTANDING CLINICS	0	78,705	0	25,635	104,340	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	341,638	745,848	211,954	787,492	2,086,932	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	320,639				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	4,420	41,090			6.00
7.00	00700	OPERATION OF PLANT	0	8,971	3,751	137,018		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	807	346	2,531	9,320	8.00
9.00	00900	HOUSEKEEPING	0	6,147	470	3,438	0	9.00
10.00	01000	DIETARY	0	6,389	1,082	7,913	12	10.00
11.00	01100	CAFETERIA	0	162	602	4,398	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,084	202	1,474	0	13.00
15.00	01500	PHARMACY	0	14,825	303	2,218	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,990	1,092	7,981	0	16.00
17.00	01700	SOCIAL SERVICE	0	769	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	26,528	4,370	31,945	3,356	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18,164	4,080	29,824	1,878	50.00
53.00	05300	ANESTHESIOLOGY	0	925	58	423	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	11,432	875	6,396	649	54.00
54.01	05401	ULTRASOUND	0	2,444	236	1,724	128	54.01
56.00	05600	RADIOISOTOPE	0	6,685	189	1,383	15	56.00
57.00	05700	CT SCAN	0	6,571	238	1,738	149	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,919	0	0	28	58.00
60.00	06000	LABORATORY	0	26,432	1,182	8,638	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,665	150	1,100	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,452	316	2,310	1,275	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	619	114	836	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,427	375	2,742	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,730	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	2,401	373	2,727	0	75.01
75.02	03952	WOUND CENTER	0	2,834	975	0	0	75.02
76.00	03953	CARDIAC REHAB	0	1,889	591	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	86,297	11,118	0	112	88.00
91.00	09100	EMERGENCY	0	20,412	1,959	14,319	1,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	12,575	1,078	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	302,965	36,125	136,058	9,317	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	35	131	960	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	96	0	0	3	192.00
194.00	07950	FREESTANDING CLINICS	0	17,543	4,834	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	0	320,639	41,090	137,018	9,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	17,713					9.00
10.00	01000	DIETARY	208	41,571				10.00
11.00	01100	CAFETERIA	486	30,655	46,100			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	586	7,900		13.00
15.00	01500	PHARMACY	96	0	0	0	31,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	437	0	2,916	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	542	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,193	10,916	13,466	4,057	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,632	0	4,543	1,506	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	397	0	3,092	0	0	54.00
54.01	05401	ULTRASOUND	248	0	659	0	0	54.01
56.00	05600	RADIOISOTOPE	62	0	132	0	0	56.00
57.00	05700	CT SCAN	0	0	865	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	476	0	5,803	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	557	164	0	65.00
66.00	06600	PHYSICAL THERAPY	928	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	31,224	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	161	0	0	0	0	75.01
75.02	03952	WOUND CENTER	3	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	478	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,101	0	3,033	0	0	88.00
91.00	09100	EMERGENCY	2,015	0	7,371	2,173	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	51	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)	16,972	41,571	43,565	7,900	31,224	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	741	0	2,535	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,713	41,571	46,100	7,900	31,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,455					16.00
17.00	01700	SOCIAL SERVICE	0	1,311				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,463	1,311		260,862	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,406	0		326,590	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		3,609	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	10,111	0		246,811	0	54.00
54.01	05401	ULTRASOUND	2,414	0		14,971	0	54.01
56.00	05600	RADIOISOTOPE	429	0		11,975	0	56.00
57.00	05700	CT SCAN	2,816	0		155,835	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	805	0		5,752	0	58.00
60.00	06000	LABORATORY	7,483	0		111,672	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		28,131	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		131,882	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		4,838	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		13,651	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		4,730	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		31,224	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	0	0		13,087	0	75.01
75.02	03952	WOUND CENTER	0	0		19,694	0	75.02
76.00	03953	CARDIAC REHAB	0	0		21,016	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,019	0		393,180	0	88.00
91.00	09100	EMERGENCY	7,509	0		114,676	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		39,340	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,455	1,311	0	1,953,526	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		3,265	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		148	0	192.00
194.00	07950	FREESTANDING CLINICS	0	0		129,993	0	194.00
194.01	07951	UNUSED SPACE	0	0		0	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	49,455	1,311	0	2,086,932	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	260,862		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	326,590		50.00
53.00	05300	ANESTHESIOLOGY	3,609		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	246,811		54.00
54.01	05401	ULTRASOUND	14,971		54.01
56.00	05600	RADIOISOTOPE	11,975		56.00
57.00	05700	CT SCAN	155,835		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,752		58.00
60.00	06000	LABORATORY	111,672		60.00
65.00	06500	RESPIRATORY THERAPY	28,131		65.00
66.00	06600	PHYSICAL THERAPY	131,882		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,838		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,651		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,730		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,224		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	13,087		75.01
75.02	03952	WOUND CENTER	19,694		75.02
76.00	03953	CARDIAC REHAB	21,016		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	393,180		88.00
91.00	09100	EMERGENCY	114,676		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	39,340		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,953,526		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,265		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	148		192.00
194.00	07950	FREESTANDING CLINICS	129,993		194.00
194.01	07951	UNUSED SPACE	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,086,932		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,738					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			766,892			2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	11,202,614		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,679	5,537	123,023	2,308,279	-4,974,951	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	608	178,596	0	6.00
7.00	00700	OPERATION OF PLANT	5,710	756	55,867	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	0	260,445	0	9.00
10.00	01000	DIETARY	1,648	0	8,124	218,079	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	264	85,721	0	13.00
15.00	01500	PHARMACY	462	0	1,959	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,662	1,377	4,470	147,375	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	36,561	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653	0	48,727	1,047,358	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	0	137,810	516,348	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	1,229	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,332	0	194,358	291,456	0	54.00
54.01	05401	ULTRASOUND	359	0	3,192	81,258	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	10,013	0	56.00
57.00	05700	CT SCAN	362	0	243	71,427	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,799	0	41,308	499,819	0	60.00
65.00	06500	RESPIRATORY THERAPY	229	0	5,362	48,694	0	65.00
66.00	06600	PHYSICAL THERAPY	481	11,421	20,378	465,480	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	174	0	1,371	23,596	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	568	0	1,315	0	0	75.01
75.02	03952	WOUND CENTER	1,485	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	899	0	8,222	71,666	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	51,290	3,123,510	0	88.00
91.00	09100	EMERGENCY	2,982	0	24,934	674,589	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,641	0	7,874	468,583	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,179	27,343	741,928	10,628,853	-4,974,951	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	7,359	0	24,964	573,761	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	745,848	211,954	787,492	2,864,670		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.695001	7.751673	1.026862	0.255714		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,365,492					5.00
6.00	00600	MAINTENANCE & REPAIRS	266,965	62,556				6.00
7.00	00700	OPERATION OF PLANT	541,834	5,710	28,535			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,727	527	527	12,203		8.00
9.00	00900	HOUSEKEEPING	371,257	716	716	0	113,900	9.00
10.00	01000	DIETARY	385,898	1,648	1,648	16	1,340	10.00
11.00	01100	CAFETERIA	9,797	916	916	0	3,122	11.00
13.00	01300	NURSING ADMINISTRATION	125,894	307	307	0	0	13.00
15.00	01500	PHARMACY	895,408	462	462	0	620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	241,004	1,662	1,662	0	2,810	16.00
17.00	01700	SOCIAL SERVICE	46,468	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,206	6,653	6,653	4,391	26,952	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,097,048	6,211	6,211	2,459	16,926	50.00
53.00	05300	ANESTHESIOLOGY	55,846	88	88	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	690,452	1,332	1,332	850	2,552	54.00
54.01	05401	ULTRASOUND	147,593	359	359	168	1,595	54.01
56.00	05600	RADIOISOTOPE	403,762	288	288	20	400	56.00
57.00	05700	CT SCAN	396,896	362	362	195	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	297,118	0	0	37	0	58.00
60.00	06000	LABORATORY	1,596,441	1,799	1,799	0	3,060	60.00
65.00	06500	RESPIRATORY THERAPY	100,538	229	229	0	0	65.00
66.00	06600	PHYSICAL THERAPY	752,077	481	481	1,670	5,968	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	37,404	174	174	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,355	571	571	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	285,666	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	145,006	568	568	0	1,035	75.01
75.02	03952	WOUND CENTER	171,174	1,485	0	0	20	75.02
76.00	03953	CARDIAC REHAB	114,116	899	0	0	3,076	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,211,706	16,927	0	147	26,370	88.00
91.00	09100	EMERGENCY	1,232,858	2,982	2,982	2,246	12,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	759,517	1,641	0	0	331	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,298,031	54,997	28,335	12,199	109,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,139	200	200	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	4	0	192.00
194.00	07950	FREESTANDING CLINICS	1,059,544	7,359	0	0	4,768	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	4,974,951	335,548	711,658	77,215	488,330	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.256898	5.363962	24.939828	6.327542	4.287357	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	320,639	41,090	137,018	9,320	17,713	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016557	0.656851	4.801752	0.763747	0.155514	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	35,641					10.00
11.00	01100	CAFETERIA	26,282	3,146				11.00
13.00	01300	NURSING ADMINISTRATION	0	40	104,891			13.00
15.00	01500	PHARMACY	0	0	0	888,455		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	199	0	0	1,844	16.00
17.00	01700	SOCIAL SERVICE	0	37	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,359	919	53,857	0	241	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	310	19,995	0	127	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	211	0	0	377	54.00
54.01	05401	ULTRASOUND	0	45	0	0	90	54.01
56.00	05600	RADIOISOTOPE	0	9	0	0	16	56.00
57.00	05700	CT SCAN	0	59	0	0	105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	30	58.00
60.00	06000	LABORATORY	0	396	0	0	279	60.00
65.00	06500	RESPIRATORY THERAPY	0	38	2,181	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	888,455	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	207	0	0	299	88.00
91.00	09100	EMERGENCY	0	503	28,858	0	280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,641	2,973	104,891	888,455	1,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FREESTANDING CLINICS	0	173	0	0	0	194.00
194.01	07951	UNUSED SPACE	0	0	0	0	0	194.01
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)	540,821	452,263	173,290	1,142,095	393,937	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.174125	143.758106	1.652096	1.285484	213.631779	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,571	46,100	7,900	31,224	49,455	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.166381	14.653528	0.075316	0.035144	26.819414	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 10/28/2013 10:33 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	3,088			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,088			30.00
		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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,088	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	FREESTANDING CLINICS	0	0		194.00
194.01	07951	UNUSED SPACE	0	0		194.01
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)	63,725	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.636334	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,311	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.424547	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/28/2013 10:33 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,837,074		2,837,074	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,759,951		1,759,951	0	0	50.00
53.00	05300	ANESTHESIOLOGY	72,860		72,860	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,035,385		1,035,385	0	0	54.00
54.01	05401	ULTRASOUND	229,985		229,985	0	0	54.01
56.00	05600	RADIOISOTOPE	522,770		522,770	0	0	56.00
57.00	05700	CT SCAN	541,975		541,975	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	380,090		380,090	0	0	58.00
60.00	06000	LABORATORY	2,190,731		2,190,731	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	142,371	0	142,371	0	0	65.00
66.00	06600	PHYSICAL THERAPY	996,014	0	996,014	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	52,286		52,286	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	353,342		353,342	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	359,053		359,053	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,142,095		1,142,095	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	203,908		203,908	0	0	75.01
75.02	03952	WOUND CENTER	223,199		223,199	0	0	75.02
76.00	03953	CARDIAC REHAB	161,442		161,442	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,848,994		6,848,994	0	0	88.00
91.00	09100	EMERGENCY	1,889,501		1,889,501	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,783		475,783		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	964,856		964,856		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,383,665	0	23,383,665	0	0	200.00
201.00		Less Observation Beds	475,783		475,783		0	201.00
202.00		Total (see instructions)	22,907,882	0	22,907,882	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/28/2013 10:33 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	972,202		972,202			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	439,160	3,665,112	4,104,272	0.428810	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	26,581	258,324	284,905	0.255734	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	76,448	2,423,291	2,499,739	0.414197	0.000000	54.00
54.01	05401	ULTRASOUND	254,114	2,163,815	2,417,929	0.095117	0.000000	54.01
56.00	05600	RADIOISOTOPE	94,800	1,395,040	1,489,840	0.350890	0.000000	56.00
57.00	05700	CT SCAN	369,090	7,580,456	7,949,546	0.068177	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,853	1,761,031	1,821,884	0.208625	0.000000	58.00
60.00	06000	LABORATORY	802,232	7,674,013	8,476,245	0.258455	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	102,874	136,298	239,172	0.595266	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	445,931	3,719,456	4,165,387	0.239117	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	26,614	355,617	382,231	0.136792	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,332	419,889	566,221	0.624035	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	344,238	265,859	610,097	0.588518	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	974,769	1,662,405	2,637,174	0.433075	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	0	728,700	728,700	0.279824	0.000000	75.01
75.02	03952	WOUND CENTER	1,749	529,038	530,787	0.420506	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	149,027	149,027	1.083307	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,066,340	5,066,340			88.00
91.00	09100	EMERGENCY	122,843	3,955,615	4,078,458	0.463288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,497	247,954	257,451	1.848053	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,231,658	1,231,658			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,270,327	45,388,938	50,659,265			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,270,327	45,388,938	50,659,265			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 10/28/2013 10:33 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
		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
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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 PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	75.00
75.01	03951	SLEEP LAB	0.000000	75.01
75.02	03952	WOUND CENTER	0.000000	75.02
76.00	03953	CARDIAC REHAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 10/28/2013 10:33 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	326,590	4,104,272	0.079573	224,473	17,862	50.00
53.00	05300	ANESTHESIOLOGY	3,609	284,905	0.012667	14,193	180	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	246,811	2,499,739	0.098735	45,729	4,515	54.00
54.01	05401	ULTRASOUND	14,971	2,417,929	0.006192	174,506	1,081	54.01
56.00	05600	RADIOISOTOPE	11,975	1,489,840	0.008038	69,471	558	56.00
57.00	05700	CT SCAN	155,835	7,949,546	0.019603	234,535	4,598	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,752	1,821,884	0.003157	37,106	117	58.00
60.00	06000	LABORATORY	111,672	8,476,245	0.013175	505,834	6,664	60.00
65.00	06500	RESPIRATORY THERAPY	28,131	239,172	0.117618	61,389	7,220	65.00
66.00	06600	PHYSICAL THERAPY	131,882	4,165,387	0.031661	105,861	3,352	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,838	382,231	0.012657	20,170	255	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,651	566,221	0.024109	94,879	2,287	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,730	610,097	0.007753	284,208	2,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,224	2,637,174	0.011840	525,322	6,220	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	13,087	728,700	0.017959	0	0	75.01
75.02	03952	WOUND CENTER	19,694	530,787	0.037103	0	0	75.02
76.00	03953	CARDIAC REHAB	21,016	149,027	0.141021	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	393,180	5,066,340	0.077606	0	0	88.00
91.00	09100	EMERGENCY	114,676	4,078,458	0.028117	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,451	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,653,324	48,455,405		2,397,676	57,112	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/28/2013 10:33 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 10/28/2013 10:33 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	4,104,272	0.000000	0.000000	224,473	50.00
53.00	05300	ANESTHESIOLOGY	0	284,905	0.000000	0.000000	14,193	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,499,739	0.000000	0.000000	45,729	54.00
54.01	05401	ULTRASOUND	0	2,417,929	0.000000	0.000000	174,506	54.01
56.00	05600	RADIOISOTOPE	0	1,489,840	0.000000	0.000000	69,471	56.00
57.00	05700	CT SCAN	0	7,949,546	0.000000	0.000000	234,535	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,821,884	0.000000	0.000000	37,106	58.00
60.00	06000	LABORATORY	0	8,476,245	0.000000	0.000000	505,834	60.00
65.00	06500	RESPIRATORY THERAPY	0	239,172	0.000000	0.000000	61,389	65.00
66.00	06600	PHYSICAL THERAPY	0	4,165,387	0.000000	0.000000	105,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	382,231	0.000000	0.000000	20,170	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	566,221	0.000000	0.000000	94,879	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	610,097	0.000000	0.000000	284,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,637,174	0.000000	0.000000	525,322	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	75.00
75.01	03951	SLEEP LAB	0	728,700	0.000000	0.000000	0	75.01
75.02	03952	WOUND CENTER	0	530,787	0.000000	0.000000	0	75.02
76.00	03953	CARDIAC REHAB	0	149,027	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,066,340	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	4,078,458	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	257,451	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	48,455,405			2,397,676	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 10/28/2013 10:33 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
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
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 PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		75.00
75.01	03951	SLEEP LAB	0	0	0		75.01
75.02	03952	WOUND CENTER	0	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/28/2013 10:33 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	0.428810	0	1,143,989	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.255734	0	21,803	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.414197	0	859,520	0	0	54.00
54.01	05401	ULTRASOUND	0.095117	0	953,268	0	0	54.01
56.00	05600	RADIOISOTOPE	0.350890	0	750,772	0	0	56.00
57.00	05700	CT SCAN	0.068177	0	2,895,109	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208625	0	537,655	0	0	58.00
60.00	06000	LABORATORY	0.258455	0	3,362,424	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.595266	0	92,467	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.239117	0	1,288,955	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136792	0	168,997	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624035	0	189,859	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.588518	0	79,680	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.433075	0	1,091,139	3,648	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.279824	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.420506	0	369,236	0	0	75.02
76.00	03953	CARDIAC REHAB	1.083307	0	99,256	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.463288	0	746,963	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848053	0	123,695	0	0	92.00
200.00		Subtotal (see instructions)		0	14,774,787	3,648	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	14,774,787	3,648	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 10/28/2013 10:33 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	490,554	0	50.00
53.00	05300	ANESTHESIOLOGY	5,576	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	356,011	0	54.00
54.01	05401	ULTRASOUND	90,672	0	54.01
56.00	05600	RADIOISOTOPE	263,438	0	56.00
57.00	05700	CT SCAN	197,380	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,168	0	58.00
60.00	06000	LABORATORY	869,035	0	60.00
65.00	06500	RESPIRATORY THERAPY	55,042	0	65.00
66.00	06600	PHYSICAL THERAPY	308,211	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	23,117	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,479	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	46,893	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	472,545	1,580	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	75.00
75.01	03951	SLEEP LAB	0	0	75.01
75.02	03952	WOUND CENTER	155,266	0	75.02
76.00	03953	CARDIAC REHAB	107,525	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	346,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	228,595	0	92.00
200.00		Subtotal (see instructions)	4,246,566	1,580	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,246,566	1,580	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/28/2013 10:33 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	0.428810	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.255734	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.414197	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.095117	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.350890	0	0	0	0	56.00
57.00	05700	CT SCAN	0.068177	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208625	0	0	0	0	58.00
60.00	06000	LABORATORY	0.258455	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.595266	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.239117	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136792	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624035	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.588518	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.433075	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.279824	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.420506	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	1.083307	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.463288	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848053	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 10/28/2013 10:33 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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/28/2013 10:33 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,073	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,173	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)	1,665	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	426	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)	423	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	41	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,128	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)	426	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)	354	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	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,837,074	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)	1,320	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)	5,413	25.00
26.00	Total swing-bed cost (see instructions)	801,889	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,035,185	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,089,951	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,089,951	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.867226	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)	654.63	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,035,185	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)	936.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,056,462	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,056,462	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/28/2013 10:33 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)	832,857	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,889,319	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)	398,983	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	331,549	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	730,532	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)	508	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	936.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	475,783	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 10/28/2013 10:33 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 10/28/2013 10:33 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		564,000		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.428810	224,473	96,256	50.00
53.00	05300	ANESTHESIOLOGY	0.255734	14,193	3,630	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.414197	45,729	18,941	54.00
54.01	05401	ULTRASOUND	0.095117	174,506	16,598	54.01
56.00	05600	RADIOISOTOPE	0.350890	69,471	24,377	56.00
57.00	05700	CT SCAN	0.068177	234,535	15,990	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208625	37,106	7,741	58.00
60.00	06000	LABORATORY	0.258455	505,834	130,735	60.00
65.00	06500	RESPIRATORY THERAPY	0.595266	61,389	36,543	65.00
66.00	06600	PHYSICAL THERAPY	0.239117	105,861	25,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136792	20,170	2,759	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624035	94,879	59,208	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.588518	284,208	167,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.433075	525,322	227,504	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.279824	0	0	75.01
75.02	03952	WOUND CENTER	0.420506	0	0	75.02
76.00	03953	CARDIAC REHAB	1.083307	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.463288	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848053	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,397,676	832,857	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,397,676		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3

Component CCN: 14Z349 | Date/Time Prepared: 10/28/2013 10:33 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	0.428810	7,337	3,146	50.00
53.00	05300	ANESTHESIOLOGY	0.255734	371	95	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.414197	8,364	3,464	54.00
54.01	05401	ULTRASOUND	0.095117	6,925	659	54.01
56.00	05600	RADIOISOTOPE	0.350890	5,535	1,942	56.00
57.00	05700	CT SCAN	0.068177	36,143	2,464	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.208625	2,104	439	58.00
60.00	06000	LABORATORY	0.258455	88,565	22,890	60.00
65.00	06500	RESPIRATORY THERAPY	0.595266	17,696	10,534	65.00
66.00	06600	PHYSICAL THERAPY	0.239117	271,241	64,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.136792	1,358	186	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624035	15,256	9,520	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.588518	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.433075	204,021	88,356	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.279824	0	0	75.01
75.02	03952	WOUND CENTER	0.420506	1,734	729	75.02
76.00	03953	CARDIAC REHAB	1.083307	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.463288	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.848053	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		666,650	209,282	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)		666,650		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 10/28/2013 10:33 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,248,146	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)	4,248,146	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)	4,290,627	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	30,293	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,263,547	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)	1,996,787	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)	1,996,787	30.00
31.00	Primary payer payments	126	31.00
32.00	Subtotal (line 30 minus line 31)	1,996,661	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)	413,001	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	413,001	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	347,768	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,409,662	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	SEQUESTRATION	-12,015	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,397,647	40.00
41.00	Interim payments	2,338,361	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)	59,286	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/28/2013 10:33 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		1,386,472		2,307,695	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/26/2012	21,170	11/26/2012	3,212	3.01
3.02		05/20/2013	24,870	05/20/2013	27,454	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)		46,040		30,666	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,432,512		2,338,361	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		237,566		59,286	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,670,078		2,397,647	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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 10/28/2013 10:33 am

Component CCN: 14Z349 | 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		823,724		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/26/2012	29,016		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		29,016		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)		852,740		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		75,896		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		928,636		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 FOR HIT	Provider CCN: 141349	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 10/28/2013 10:33 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	577	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,128	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,665	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	50,659,265	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	282,357	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-2 | Date/Time Prepared: 10/28/2013 10:33 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)	737,837	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)	211,375	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	780	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)	949,212	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	949,212	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)	949,212	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,922	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)	933,290	0	15.00
16.00	SEQUESTRATION	-4,654	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	928,636	0	19.00
20.00	Interim payments	852,740	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)	75,896	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: 141349	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 10/28/2013 10:33 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	1,889,319	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)	1,889,319	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,908,212	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)	1,908,212	19.00
20.00	Deductibles (exclude professional component)	274,773	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,633,439	22.00
23.00	Coinsurance	2,657	23.00
24.00	Subtotal (line 22 minus line 23)	1,630,782	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,665	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,665	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,557	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,678,447	28.00
29.00	SEQUESTRATION	-8,369	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,670,078	30.00
31.00	Interim payments	1,432,512	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)	237,566	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 10/28/2013 10:33 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	8,232,309	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	3,963,534	0	0	0	4.00
5.00	Other receivable	200,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	642,702	0	0	0	8.00
9.00	Other current assets	524,997	0	0	0	9.00
10.00	Due from other funds	365,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,928,542	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	926,751	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	15,481,197	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,335,572	0	0	0	23.00
24.00	Accumulated depreciation	-18,062,650	0	0	0	24.00
25.00	Minor equipment depreciable	92,896	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)	8,773,766	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,171,605	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	86,678	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,258,283	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,960,591	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	560,888	0	0	0	37.00
38.00	Salaries, wages, and fees payable	498,261	0	0	0	38.00
39.00	Payroll taxes payable	1,153,694	0	0	0	39.00
40.00	Notes and loans payable (short term)	382,439	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	474,905	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,070,187	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,974,733	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	3,974,733	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,044,920	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,915,671				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)	17,915,671	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,960,591	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 10/28/2013 10:33 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		18,208,490		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-292,819				2.00
3.00	Total (sum of line 1 and line 2)		17,915,671		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)		17,915,671		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)		17,915,671		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: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/28/2013 10:33 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	853,702		853,702	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	118,860		118,860	5.00
6.00	Swing bed - NF	7,140		7,140	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	979,702		979,702	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)	979,702		979,702	17.00
18.00	Ancillary services	4,219,734	35,455,219	39,674,953	18.00
19.00	Outpatient services	133,266	4,231,069	4,364,335	19.00
20.00	RURAL HEALTH CLINIC	0	5,066,340	5,066,340	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,231,658	1,231,658	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CLINICS & PHYSICIAN CHARGE	38,843	695,991	734,834	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,371,545	46,680,277	52,051,822	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,962,861		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	INTEREST EXPENSE	164,395			37.00
38.00	NONOPERATING EXPENSES	2,620			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)		167,015		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,795,846		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 10/28/2013 10:33 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,051,822	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,268,290	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,783,532	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,795,846	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,012,314	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	332,029	6.00
7.00	Income from investments	64,936	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	27,265	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	41,438	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	9,831	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	27,705	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	21,100	22.00
23.00	Governmental appropriations	242,837	23.00
24.00	OTHER MISCELLANEOUS	116,749	24.00
25.00	Total other income (sum of lines 6-24)	883,890	25.00
26.00	Total (line 5 plus line 25)	-128,424	26.00
27.00	INTEREST EXPENSE	164,395	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	164,395	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-292,819	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H

HHA CCN: 147694 | Date/Time Prepared: 10/28/2013 10:33 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	16,358	16,358	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	134,675	0	0	0	89,638	224,313	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	259,101	0	0	0	0	259,101	6.00
7.00	Physical Therapy	74,011	0	0	9,641	0	83,652	7.00
8.00	Occupational Therapy	0	0	0	20,456	0	20,456	8.00
9.00	Speech Pathology	0	0	0	9,330	0	9,330	9.00
10.00	Medical Social Services	0	0	0	300	0	300	10.00
11.00	Home Health Aide	796	0	0	0	0	796	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	468,583	0	0	39,727	105,996	614,306	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	16,358	0	16,358			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-248	224,065	0	224,065			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	259,101	0	259,101			6.00
7.00	Physical Therapy	0	83,652	0	83,652			7.00
8.00	Occupational Therapy	0	20,456	0	20,456			8.00
9.00	Speech Pathology	0	9,330	0	9,330			9.00
10.00	Medical Social Services	0	300	0	300			10.00
11.00	Home Health Aide	0	796	0	796			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-248	614,058	0	614,058			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-1 Part I | Date/Time Prepared: 10/28/2013 10:33 am

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	16,358	0	0	16,358		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	224,065	0	0	16,358	0	240,423	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	259,101	0	0	0	0	259,101	6.00
7.00	Physical Therapy	83,652	0	0	0	0	83,652	7.00
8.00	Occupational Therapy	20,456	0	0	0	0	20,456	8.00
9.00	Speech Pathology	9,330	0	0	0	0	9,330	9.00
10.00	Medical Social Services	300	0	0	0	0	300	10.00
11.00	Home Health Aide	796	0	0	0	0	796	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	614,058	0	0	16,358	0	614,058	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	240,423		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	166,723	425,824	6.00
7.00	Physical Therapy	53,828	137,480	7.00
8.00	Occupational Therapy	13,163	33,619	8.00
9.00	Speech Pathology	6,004	15,334	9.00
10.00	Medical Social Services	193	493	10.00
11.00	Home Health Aide	512	1,308	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		614,058	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-1 Part II Date/Time Prepared: 10/28/2013 10:33 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	1,641		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	1,641	0	-240,423	373,635	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	259,101	6.00
7.00	Physical Therapy	0	0	0	0	0	83,652	7.00
8.00	Occupational Therapy	0	0	0	0	0	20,456	8.00
9.00	Speech Pathology	0	0	0	0	0	9,330	9.00
10.00	Medical Social Services	0	0	0	0	0	300	10.00
11.00	Home Health Aide	0	0	0	0	0	796	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-240,423	373,635	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	16,358	0		240,423	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	9.968312	0.000000		0.643470	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I | Date/Time Prepared: 10/28/2013 10:33 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	17,550	0	8,086	34,438	60,074	1.00
2.00	Skilled Nursing Care	425,824	0	0	0	66,255	492,079	2.00
3.00	Physical Therapy	137,480	0	0	0	18,926	156,406	3.00
4.00	Occupational Therapy	33,619	0	0	0	0	33,619	4.00
5.00	Speech Pathology	15,334	0	0	0	0	15,334	5.00
6.00	Medical Social Services	493	0	0	0	0	493	6.00
7.00	Home Health Aide	1,308	0	0	0	204	1,512	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	614,058	17,550	0	8,086	119,823	759,517	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	15,433	8,802	0	0	1,419	0	1.00
2.00	Skilled Nursing Care	126,414	0	0	0	0	0	2.00
3.00	Physical Therapy	40,180	0	0	0	0	0	3.00
4.00	Occupational Therapy	8,637	0	0	0	0	0	4.00
5.00	Speech Pathology	3,939	0	0	0	0	0	5.00
6.00	Medical Social Services	127	0	0	0	0	0	6.00
7.00	Home Health Aide	388	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	195,118	8,802	0	0	1,419	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part I | Date/Time Prepared: 10/28/2013 10:33 am

HHA CCN: 147694 | Home Health Agency I | PPS

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

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	85,728	0	85,728				1.00
2.00	Skilled Nursing Care	618,493	0	618,493	60,313	678,806		2.00
3.00	Physical Therapy	196,586	0	196,586	19,170	215,756		3.00
4.00	Occupational Therapy	42,256	0	42,256	4,121	46,377		4.00
5.00	Speech Pathology	19,273	0	19,273	1,879	21,152		5.00
6.00	Medical Social Services	620	0	620	60	680		6.00
7.00	Home Health Aide	1,900	0	1,900	185	2,085		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	964,856	0	964,856	85,728	964,856		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.097515			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-2 Part II Date/Time Prepared: 10/28/2013 10:33 am

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,641	0	7,874	134,675	0	60,074	1.00
2.00	Skilled Nursing Care	0	0	0	259,101	0	492,079	2.00
3.00	Physical Therapy	0	0	0	74,011	0	156,406	3.00
4.00	Occupational Therapy	0	0	0	0	0	33,619	4.00
5.00	Speech Pathology	0	0	0	0	0	15,334	5.00
6.00	Medical Social Services	0	0	0	0	0	493	6.00
7.00	Home Health Aide	0	0	0	796	0	1,512	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,641	0	7,874	468,583		759,517	20.00
21.00	Total cost to be allocated	17,550	0	8,086	119,823		195,118	21.00
22.00	Unit cost multiplier	10.694698	0.000000	1.026924	0.255714		0.256897	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	0	0	331	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,641	0	0	331	0	0	20.00
21.00	Total cost to be allocated	8,802	0	0	1,419	0	0	21.00
22.00	Unit cost multiplier	5.363803	0.000000	0.000000	4.287009	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

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

Worksheet H-2 Part II Date/Time Prepared: 10/28/2013 10:33 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 10/28/2013 10:33 am

HHA CCN: 147694 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	678,806		678,806	3,255	208.54	1.00
2.00	Physical Therapy	3.00	215,756	0	215,756	2,308	93.48	2.00
3.00	Occupational Therapy	4.00	46,377	0	46,377	226	205.21	3.00
4.00	Speech Pathology	5.00	21,152	0	21,152	86	245.95	4.00
5.00	Medical Social Services	6.00	680		680	3	226.67	5.00
6.00	Home Health Aide	7.00	2,085		2,085	10	208.50	6.00
7.00	Total (sum of lines 1-6)		964,856	0	964,856	5,888		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	1,174	963			8.00
8.01	Skilled Nursing Care		41180	107	33			8.01
9.00	Physical Therapy		99914	1,052	616			9.00
9.01	Physical Therapy		41180	150	13			9.01
10.00	Occupational Therapy		99914	44	93			10.00
10.01	Occupational Therapy		41180	0	0			10.01
11.00	Speech Pathology		99914	4	71			11.00
11.01	Speech Pathology		41180	0	0			11.01
12.00	Medical Social Services		99914	4	1			12.00
12.01	Medical Social Services		41180	0	0			12.01
13.00	Home Health Aide		99914	1	7			13.00
13.01	Home Health Aide		41180	0	0			13.01
14.00	Total (sum of lines 8-13)			2,536	1,797			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	18,799	18,799	30,125	0.624033	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,281	996		267,140	207,706		1.00
2.00	Physical Therapy	1,202	629		112,363	58,799		2.00
3.00	Occupational Therapy	44	93		9,029	19,085		3.00
4.00	Speech Pathology	4	71		984	17,462		4.00
5.00	Medical Social Services	4	1		907	227		5.00
6.00	Home Health Aide	1	7		209	1,460		6.00
7.00	Total (sum of lines 1-6)	2,536	1,797		390,632	304,739		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part I | Date/Time Prepared: 10/28/2013 10:33 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	474,846						1.00
2.00	Physical Therapy	171,162						2.00
3.00	Occupational Therapy	28,114						3.00
4.00	Speech Pathology	18,446						4.00
5.00	Medical Social Services	1,134						5.00
6.00	Home Health Aide	1,669						6.00
7.00	Total (sum of lines 1-6)	695,371						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-3 Part II | Date/Time Prepared: 10/28/2013 10:33 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.239117	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.624035	30,125	18,799	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.433075	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-4 Part I-II
HHA CCN: 147694 | Date/Time Prepared: 10/28/2013 10:33 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	415,641	269,143	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	3,608	9,571	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,689	3,688	13.00
14.00	Total PPS Reimbursement - PEP Episodes	3,522	1,003	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	1,261	2,164	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	426,721	285,569	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	426,721	285,569	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	426,721	285,569	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	426,721	285,569	29.00
30.00	SEQUESTRATION	-2,044	-1,358	30.00
31.00	Subtotal (line 29 plus/minus line 30)	424,677	284,211	31.00
32.00	Interim payments (see instructions)	424,677	284,211	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

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

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2012 To 06/30/2013 | Worksheet H-5 | Date/Time Prepared: 10/28/2013 10:33 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		424,677		284,211	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		424,677		284,211	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		424,677		284,211	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 10/28/2013 10:33 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,391,010	0	1,391,010	0	1,391,010	1.00
2.00	Physician Assistant	209,814	0	209,814	0	209,814	2.00
3.00	Nurse Practitioner	422,134	0	422,134	0	422,134	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	737,822	0	737,822	0	737,822	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,760,780	0	2,760,780	0	2,760,780	10.00
11.00	Physician Services Under Agreement	0	279,159	279,159	0	279,159	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	279,159	279,159	0	279,159	14.00
15.00	Medical Supplies	0	34,051	34,051	0	34,051	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	149,630	149,630	0	149,630	18.00
19.00	Other Health Care Costs	0	11,537	11,537	0	11,537	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	195,218	195,218	0	195,218	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,760,780	474,377	3,235,157	0	3,235,157	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	254,049	254,049	0	254,049	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	17,312	17,312	0	17,312	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	271,361	271,361	0	271,361	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	111,322	111,322	0	111,322	29.00
30.00	Administrative Costs	362,730	421,731	784,461	-256,547	527,914	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	362,730	533,053	895,783	-256,547	639,236	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,123,510	1,278,791	4,402,301	-256,547	4,145,754	32.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 10/28/2013 10:33 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,391,010		1.00
2.00	Physician Assistant	0	209,814		2.00
3.00	Nurse Practitioner	0	422,134		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	737,822		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,760,780		10.00
11.00	Physician Services Under Agreement	0	279,159		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	279,159		14.00
15.00	Medical Supplies	0	34,051		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	149,630		18.00
19.00	Other Health Care Costs	0	11,537		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	195,218		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,235,157		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	254,049		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	17,312		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	271,361		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	111,322		29.00
30.00	Administrative Costs	0	527,914		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	639,236		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,145,754		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141349 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-2

Component CCN: 143464 | Date/Time Prepared: 10/28/2013 10:33 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	5.91	22,712	4,200	24,822		1.00
2.00	Physician Assistant	1.83	5,568	2,100	3,843		2.00
3.00	Nurse Practitioner	4.41	13,972	2,100	9,261		3.00
4.00	Subtotal (sum of lines 1-3)	12.15	42,252		37,926	42,252	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)	12.15	42,252			42,252	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)					3,235,157	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					271,361	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,506,518	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.922612	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					639,236	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,703,240	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,342,476	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					3,342,476	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					3,083,808	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					6,318,965	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3 Date/Time Prepared: 10/28/2013 10:33 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)		6,318,965	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		130,927	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		6,188,038	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		42,252	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)		42,252	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		146.46	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)	146.46	146.46	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	5,420	5,420	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	793,813	793,813	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,587,626	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,181,319	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,014	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		29,585	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,138,231	16.04
16.05	Total program cost (see instructions)		1,167,816	16.05
17.00	Primary payer amounts		280	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		135,252	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		204,811	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,167,536	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		39,699	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,207,235	22.00
23.00	Reimbursable bad debts (see instructions)		14,312	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		13,693	24.00
25.00	SEQUESTRATION		-6,091	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		1,215,456	26.00
27.00	Interim payments		1,113,738	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)		101,718	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: 141349 | Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-4 | Date/Time Prepared: 10/28/2013 10:33 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,760,780	2,760,780	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000574	0.002016	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,585	5,566	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	32,938	24,306	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	34,523	29,872	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	3,235,157	3,235,157	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	3,342,476	3,342,476	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010671	0.009234	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	35,668	30,864	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	70,191	60,736	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	522	1,833	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	134.47	33.13	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	90	833	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	12,102	27,597	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)		130,927	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)		39,699	16.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-5 | Date/Time Prepared: 10/28/2013 10:33 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,085,918	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		11/26/2012	27,820	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		27,820	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,113,738	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		101,718	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,215,456	7.00

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