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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet S Parts I-III Date/Time Prepared: 9/13/2014 3:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/13/2014 Time: 3:18 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL (141319) for the cost reporting period beginning 06/01/2013 and ending 05/31/2014 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	159,665	-3,698	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	-15,290	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-26		0	7.00
9.00	HOME HEALTH AGENCY I	0	1	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	144,376	-3,723	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: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HAMMOND-HENRY SWING BED	14Z319	19340		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HAMMOND-HENRY SKILLED NURSING	145464	19340		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HAMMOND-HENRY HOME HEALTH SERVICES	147450	19340		06/05/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2013	05/31/2014	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		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	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	414,218	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 high cost 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet S-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

		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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	07/15/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 9/13/2014 2:33 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	79,224.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	79,224.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	79,224.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	37	13,505		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		62				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 9/13/2014 2:33 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,551	422	3,301			1.00
2.00	HMO and other (see instructions)	193	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	802	0	917			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,353	422	4,220			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		209	435			13.00
14.00	Total (see instructions)	2,353	631	4,655	0.00	200.76	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	926	0	13,084	0.00	24.92	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	9,041	0	11,114	0.00	8.97	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	234.65	27.00
28.00	Observation Bed Days		0	667			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 9/13/2014 2:33 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	502	199	1,181	1.00
2.00	HMO and other (see instructions)			60			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	502	199	1,181	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 141319 Component CCN: 147450	Period: From 06/01/2013 To 05/31/2014	Worksheet S-4 Date/Time Prepared: 9/13/2014 2:33 pm
		Home Health Agency I	PPS

						1.00	
0.00	County				HENRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	15,164	0	0	15,164	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	265.00	0.00	0.00	265.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.99	0.00	0.99	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.04	0.00	1.04	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			7.29	0.00	7.29	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			5			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			19340			20.00
20.01				37900			20.01
20.02				99914			20.02
20.03				50208			20.03
20.04				49740			20.04
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,101	426	146	68	4,741	21.00
22.00	Skilled Nursing Visit Charges	518,224	56,649	15,413	8,382	598,668	22.00
23.00	Physical Therapy Visits	1,553	59	13	19	1,644	23.00
24.00	Physical Therapy Visit Charges	261,739	10,021	2,208	3,227	277,195	24.00
25.00	Occupational Therapy Visits	839	52	4	5	900	25.00
26.00	Occupational Therapy Visit Charges	141,485	8,832	679	849	151,845	26.00
27.00	Speech Pathology Visits	74	18	0	0	92	27.00
28.00	Speech Pathology Visit Charges	12,399	3,057	0	0	15,456	28.00
29.00	Medical Social Service Visits	16	1	1	1	19	29.00
30.00	Medical Social Service Visit Charges	3,328	208	208	208	3,952	30.00
31.00	Home Health Aide Visits	1,333	283	12	17	1,645	31.00
32.00	Home Health Aide Visit Charges	94,931	20,311	655	1,165	117,062	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,916	839	176	110	9,041	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,032,106	99,078	19,163	13,831	1,164,178	35.00
36.00	Total Number of Episodes (standard/non outlier)	398		46	6	450	36.00
37.00	Total Number of Outlier Episodes		16		2	18	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-7 | Date/Time Prepared: 9/13/2014 2:33 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	05/21/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	30	0	30	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	28	0	28	12.00
13.00		RUB	123	0	123	13.00
14.00		RUA	47	0	47	14.00
15.00		RVC	50	0	50	15.00
16.00		RVB	207	0	207	16.00
17.00		RVA	192	0	192	17.00
18.00		RHC	14	0	14	18.00
19.00		RHB	89	0	89	19.00
20.00		RHA	56	0	56	20.00
21.00		RMC	12	0	12	21.00
22.00		RMB	10	0	10	22.00
23.00		RMA	32	0	32	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	13	0	13	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	9	0	9	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	10	0	10	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	4	0	4	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet S-7 | Date/Time Prepared: 9/13/2014 2:33 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	419	419	199.00
200.00	TOTAL		926	419	1,345	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	784,725	33.57	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	566	0.02	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,337,322			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet S-10 Date/Time Prepared: 9/13/2014 2:33 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.447650	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,546,806	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	733,339	5.00
6.00	Medicaid charges	5,097,572	6.00
7.00	Medicaid cost (line 1 times line 6)	2,281,928	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,783	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,783	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	308,251	160,966	469,217	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	137,989	72,056	210,045	21.00
22.00	Partial payment by patients approved for charity care	167,025	0	167,025	22.00
23.00	Cost of charity care (line 21 minus line 22)	-29,036	72,056	43,020	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,317,240	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	215,419	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,101,821	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	493,230	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	536,250	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	538,033	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,229,130	2,229,130	1,004,212	3,233,342	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,454,570	1,454,570	15,339	1,469,909	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	75,576	3,628,834	3,704,410	0	3,704,410	4.00
5.01	00520	DATA PROCESSING	357,872	292,240	650,112	0	650,112	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	107,941	4,002	111,943	0	111,943	5.02
5.03	00540	ADMITTING	150,536	17,188	167,724	0	167,724	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	268,236	225,881	494,117	-74,327	419,790	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	478,191	1,625,027	2,103,218	7,255	2,110,473	5.05
7.00	00700	OPERATION OF PLANT	191,650	936,893	1,128,543	0	1,128,543	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,206	104,014	136,220	0	136,220	8.00
9.00	00900	HOUSEKEEPING	324,634	98,707	423,341	0	423,341	9.00
10.00	01000	DIETARY	426,630	421,307	847,937	0	847,937	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	244,696	16,909	261,605	0	261,605	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,794	47,794	0	47,794	14.00
15.00	01500	PHARMACY	158,167	143,383	301,550	0	301,550	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	332,790	74,776	407,566	0	407,566	16.00
17.00	01700	SOCIAL SERVICE	121,501	886	122,387	0	122,387	17.00
18.00	01080	INSERVICE EDUCATION	92,767	27,735	120,502	0	120,502	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,907,225	192,370	2,099,595	-181,172	1,918,423	30.00
43.00	04300	NURSERY	0	846	846	151,912	152,758	43.00
44.00	04400	SKILLED NURSING FACILITY	819,439	71,285	890,724	0	890,724	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,325,222	2,241,870	3,567,092	-1,066,183	2,500,909	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	29,260	29,260	52.00
53.00	05300	ANESTHESIOLOGY	673,059	114,486	787,545	-114,486	673,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,118	1,279,925	1,917,043	29,222	1,946,265	54.00
60.00	06000	LABORATORY	592,578	810,407	1,402,985	0	1,402,985	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110,944	110,944	0	110,944	62.00
64.00	06400	INTRAVENOUS THERAPY	32,071	5,042	37,113	0	37,113	64.00
66.00	06600	PHYSICAL THERAPY	1,089,637	94,114	1,183,751	0	1,183,751	66.00
67.00	06700	OCCUPATIONAL THERAPY	349,278	26,167	375,445	0	375,445	67.00
68.00	06800	SPEECH PATHOLOGY	70,114	7,020	77,134	0	77,134	68.00
69.00	06900	ELECTROCARDIOLOGY	252,354	186,314	438,668	0	438,668	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,180,669	1,180,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	797,068	797,068	0	797,068	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	51,454	45,379	96,833	0	96,833	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	542,803	384,519	927,322	38,958	966,280	90.00
90.01	09001	OB CLINIC	358,547	39,080	397,627	0	397,627	90.01
90.02	09002	SPECIALTY CLINIC	44,000	573	44,573	0	44,573	90.02
91.00	09100	EMERGENCY	512,356	1,467,212	1,979,568	0	1,979,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	484,283	98,068	582,351	0	582,351	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,020,659	1,020,659	-1,020,659	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,104,931	20,342,624	33,447,555	0	33,447,555	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	103	2,431	2,534	0	2,534	192.02
192.03	19202	LEASED SPACE	6,368	62,479	68,847	0	68,847	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	526	238	764	0	764	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	13,111,928	20,407,772	33,519,700	0	33,519,700	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	88,839	3,322,181		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-473,623	996,286		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-272,008	3,432,402		4.00
5.01	00520	DATA PROCESSING	0	650,112		5.01
5.02	00530	PURCHASING RECEIVING AND STORES	-28,754	83,189		5.02
5.03	00540	ADMITTING	0	167,724		5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	419,790		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-166,557	1,943,916		5.05
7.00	00700	OPERATION OF PLANT	0	1,128,543		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,220		8.00
9.00	00900	HOUSEKEEPING	0	423,341		9.00
10.00	01000	DIETARY	-186,881	661,056		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	261,605		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	47,794		14.00
15.00	01500	PHARMACY	0	301,550		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,053	406,513		16.00
17.00	01700	SOCIAL SERVICE	0	122,387		17.00
18.00	01080	INSERVICE EDUCATION	0	120,502		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,918,423		30.00
43.00	04300	NURSERY	0	152,758		43.00
44.00	04400	SKILLED NURSING FACILITY	-225	890,499		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-500	2,500,409		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,260		52.00
53.00	05300	ANESTHESIOLOGY	-673,059	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-29,222	1,917,043		54.00
60.00	06000	LABORATORY	0	1,402,985		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110,944		62.00
64.00	06400	INTRAVENOUS THERAPY	0	37,113		64.00
66.00	06600	PHYSICAL THERAPY	-127,424	1,056,327		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	375,445		67.00
68.00	06800	SPEECH PATHOLOGY	0	77,134		68.00
69.00	06900	ELECTROCARDIOLOGY	-27,724	410,944		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,180,669		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	797,068		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	96,833		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-605,512	360,768		90.00
90.01	09001	OB CLINIC	-288,158	109,469		90.01
90.02	09002	SPECIALTY CLINIC	-44,000	573		90.02
91.00	09100	EMERGENCY	-519,946	1,459,622		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	-8,383	573,968		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,364,190	30,083,365		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
192.02	19201	ORTHO CLINIC	0	2,534		192.02
192.03	19202	LEASED SPACE	0	68,847		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	764		194.04
194.05	07954	COLONA CLINIC	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-3,364,190	30,155,510		200.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-6 | Date/Time Prepared: 9/13/2014 2:33 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	38,958		1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	984,182		1.00
	TOTALS		0	984,182		
	D - CAPITAL LEASE INTEREST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7,255		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,222		2.00
	TOTALS		0	36,477		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58,988		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,339		2.00
	TOTALS		0	74,327		
	F - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	29,260	0		1.00
	TOTALS		29,260	0		
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE					
1.00	OPERATING ROOM	50.00	0	114,486		1.00
	TOTALS		0	114,486		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,180,669		1.00
	TOTALS		0	1,180,669		
	I - NURSERY RECLASS					
1.00	NURSERY	43.00	151,329	583		1.00
	TOTALS		151,329	583		
500.00	Grand Total: Increases		180,589	2,429,682		500.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-6 | Date/Time Prepared: 9/13/2014 2:33 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,958	9	1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	984,182	11	1.00
	TOTALS		0	984,182		
	D - CAPITAL LEASE INTEREST					
1.00	INTEREST EXPENSE	113.00	0	36,477	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	36,477		
	E - OTHER CAPITAL COSTS					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	74,327	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	74,327		
	F - DELIVERY AND LABOR RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	29,260	0	0	1.00
	TOTALS		29,260	0		
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE					
1.00	ANESTHESIOLOGY	53.00	0	114,486	0	1.00
	TOTALS		0	114,486		
	H - IMPLANT EXP RECLASS					
1.00	OPERATING ROOM	50.00	0	1,180,669	0	1.00
	TOTALS		0	1,180,669		
	I - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	151,329	583	0	1.00
	TOTALS		151,329	583		
500.00	Grand Total: Decreases		180,589	2,429,682		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,269,519	0	0	0	0	1.00
2.00	Land Improvements	1,249,354	83,176	0	83,176	0	2.00
3.00	Buildings and Fixtures	44,517,740	0	0	0	7,761	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,231,357	0	0	0	566,950	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,267,970	83,176	0	83,176	574,711	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	59,267,970	83,176	0	83,176	574,711	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,269,519	0	1.00
2.00	Land Improvements	1,332,530	0	2.00
3.00	Buildings and Fixtures	44,509,979	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,664,407	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,776,435	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	58,776,435	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,229,130	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,454,570	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,683,700	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,229,130	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,454,570	2.00
3.00	Total (sum of lines 1-2)	0	3,683,700	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	47,112,028	0	47,112,028	0.801546	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,664,407	0	11,664,407	0.198454	0	2.00
3.00	Total (sum of lines 1-2)	58,776,435	0	58,776,435	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,190,172	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	980,947	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,171,119	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,073,021	58,988	0	0	3,322,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,339	0	0	996,286	2.00
3.00	Total (sum of lines 1-2)	1,073,021	74,327	0	0	4,318,467	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-8 | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,485,840			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-469,704	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
33.01	CAFETERIA-EMPLOYEES AND GUESTS	B	-174,006	DIETARY	10.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-8 | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-1,053	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	VENDING MACHINES	B	-660	DIETARY	10.00	0	33.03
33.04	DIETARY RECEIPTS - OTHER	B	-12,215	DIETARY	10.00	0	33.04
33.05	SUPPLIES REBATES	B	-28,210	PURCHASING RECEIVING AND STORES	5.02	0	33.05
33.06	ATHLETIC TRAINING REVENUE	B	-23,861	PHYSICAL THERAPY	66.00	0	33.06
33.07	A/P REVENUE	B	-544	PURCHASING RECEIVING AND STORES	5.02	0	33.07
33.08	PHYSICAL THERAPY TO SUMMIT	B	-72,596	PHYSICAL THERAPY	66.00	0	33.08
33.09	PT OUTREACH REVENUE	A	-30,967	PHYSICAL THERAPY	66.00	0	33.09
33.10	LIFELINE REVENUE	B	-8,383	HOME HEALTH AGENCY	101.00	0	33.10
33.11	FOUNDATION EXPENSES	B	-90,872	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	ADVERTISING EXPENSE	B	-65,861	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.12
33.13	CRNA EXPENSE	B	-673,059	ANESTHESIOLOGY	53.00	0	33.13
33.14	CRNA FRINGES	B	-139,892	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	LTC OTHER REVENUE	B	-225	SKILLED NURSING FACILITY	44.00	0	33.15
33.17	CABLE TV	A	-3,919	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	TELEPHONE SERVICES	A	-2,569	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.18
33.19	UNNECESARY BORROWING	B	-46,343	CAP REL COSTS-BLDG & FIXT	1.00	11	33.19
33.20	UNNECESSARY BORROWING - CAP LEASE	A	-7,255	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.20
33.21	UNNECESSARY BORROWING - CAP LEASE	A	-29,222	RADIOLOGY-DIAGNOSTIC	54.00	0	33.21
33.23	PHYSICIAN BENEFIT OFFSET	A	-132,116	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.25	UNAMMORTIZED BOND ISSUE COST	B	31,790	CAP REL COSTS-BLDG & FIXT	1.00	11	33.25
33.26	UNAMMORTIZED BOND ISSUE COST	B	97,163	CAP REL COSTS-BLDG & FIXT	1.00	11	33.26
33.27	UNAMMORTIZED BOND ISSUE COST	B	6,229	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,364,190				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 9/13/2014 2:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	51,200	0	51,200	0	0	1.00
2.00	91.00	EMERGENCY	1,341,515	519,946	821,569	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	27,724	27,724	0	0	0	3.00
4.00	90.00	CLINIC	347,488	347,488	0	0	0	4.00
5.00	90.00	CLINIC	258,024	258,024	0	0	0	5.00
6.00	90.01	OB CLINIC	288,158	288,158	0	0	0	6.00
7.00	90.02	SPECIALTY CLINIC	44,000	44,000	0	0	0	7.00
8.00	50.00	OPERATING ROOM	500	500	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,358,609	1,485,840	872,769		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	OB CLINIC	0	0	0	0	0	6.00
7.00	90.02	SPECIALTY CLINIC	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	519,946		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	27,724		3.00
4.00	90.00	CLINIC	0	0	0	347,488		4.00
5.00	90.00	CLINIC	0	0	0	258,024		5.00
6.00	90.01	OB CLINIC	0	0	0	288,158		6.00
7.00	90.02	SPECIALTY CLINIC	0	0	0	44,000		7.00
8.00	50.00	OPERATING ROOM	0	0	0	500		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,485,840		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,322,181	3,322,181				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	996,286		996,286			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,432,402	15,835	0	3,448,237		4.00
5.01	00520	DATA PROCESSING	650,112	65,877	134,646	105,620	956,255	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	83,189	71,063	0	31,857	11,629	5.02
5.03	00540	ADMITTING	167,724	28,387	12,742	44,428	23,414	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	419,790	26,456	930	79,166	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,943,916	75,229	20,945	141,130	155,760	5.05
7.00	00700	OPERATION OF PLANT	1,128,543	196,086	21,717	56,562	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,220	21,131	1,433	9,505	0	8.00
9.00	00900	HOUSEKEEPING	423,341	36,828	0	95,811	4,032	9.00
10.00	01000	DIETARY	661,056	83,781	6,116	125,913	9,924	10.00
11.00	01100	CAFETERIA	0	54,566	0	0	6,357	11.00
13.00	01300	NURSING ADMINISTRATION	261,605	23,173	1,047	72,218	7,523	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,794	2,924	0	0	0	14.00
15.00	01500	PHARMACY	301,550	33,932	3,660	46,680	32,717	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	406,513	38,318	4,234	98,218	56,752	16.00
17.00	01700	SOCIAL SERVICE	122,387	9,297	0	35,859	3,566	17.00
18.00	01080	INSERVICE EDUCATION	120,502	25,545	4,598	27,379	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,918,423	314,295	45,208	509,587	158,160	30.00
43.00	04300	NURSERY	152,758	6,345	6,173	44,662	0	43.00
44.00	04400	SKILLED NURSING FACILITY	890,499	404,697	35,162	241,844	29,926	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,500,409	331,702	176,402	391,118	71,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,260	2,841	0	8,636	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,917,043	205,604	354,472	188,035	30,081	54.00
60.00	06000	LABORATORY	1,402,985	64,332	24,162	174,890	20,468	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	110,944	2,124	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	37,113	4,690	0	9,465	0	64.00
66.00	06600	PHYSICAL THERAPY	1,056,327	212,914	28,617	321,589	38,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	375,445	81,050	0	103,084	4,497	67.00
68.00	06800	SPEECH PATHOLOGY	77,134	14,069	0	20,693	3,101	68.00
69.00	06900	ELECTROCARDIOLOGY	410,944	28,525	28,845	74,478	15,971	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,180,669	5,793	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	797,068	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	96,833	17,462	3,845	15,186	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	360,768	0	42,642	57,644	191,189	90.00
90.01	09001	OB CLINIC	109,469	62,732	8,476	20,774	0	90.01
90.02	09002	SPECIALTY CLINIC	573	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,459,622	165,106	18,991	151,214	68,381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	573,968	27,807	258	142,928	13,335	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,083,365	2,760,516	985,321	3,446,173	956,255	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,090	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	2,534	0	2,424	30	0	192.02
192.03	19202	LEASED SPACE	68,847	82,236	8,541	1,879	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	9,269	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	13,407	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	764	0	0	155	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	441,663	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	30,155,510	3,322,181	996,286	3,448,237	956,255	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES	197,738					5.02
5.03	00540	ADMITTING	140	276,835				5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	598	0	526,940			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,275	0	0	2,338,255	2,338,255	5.05
7.00	00700	OPERATION OF PLANT	3,607	0	0	1,406,515	120,136	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113	0	0	168,402	14,384	8.00
9.00	00900	HOUSEKEEPING	3,908	0	0	563,920	48,167	9.00
10.00	01000	DIETARY	2,227	0	0	889,017	75,934	10.00
11.00	01100	CAFETERIA	0	0	0	60,923	5,204	11.00
13.00	01300	NURSING ADMINISTRATION	290	0	0	365,856	31,249	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,507	0	0	53,225	4,546	14.00
15.00	01500	PHARMACY	167	0	0	418,706	35,763	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	320	0	0	604,355	51,620	16.00
17.00	01700	SOCIAL SERVICE	6	0	0	171,115	14,616	17.00
18.00	01080	INSERVICE EDUCATION	153	0	0	178,177	15,219	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,021	14,792	27,264	2,996,750	255,964	30.00
43.00	04300	NURSERY	48	1,520	2,802	214,308	18,305	43.00
44.00	04400	SKILLED NURSING FACILITY	2,444	0	17,873	1,622,445	138,580	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,451	66,547	108,621	3,698,267	315,881	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,486	2,738	44,961	3,840	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,863	54,459	100,378	2,860,935	244,364	54.00
60.00	06000	LABORATORY	25,773	29,518	54,406	1,796,534	153,449	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,009	1,859	115,936	9,903	62.00
64.00	06400	INTRAVENOUS THERAPY	291	12,461	22,968	86,988	7,430	64.00
66.00	06600	PHYSICAL THERAPY	1,183	17,519	32,290	1,708,894	145,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	284	5,942	10,951	581,253	49,647	67.00
68.00	06800	SPEECH PATHOLOGY	12	880	1,623	117,512	10,037	68.00
69.00	06900	ELECTROCARDIOLOGY	584	10,072	18,062	587,481	50,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,358	2,503	3,861	330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,196	11,114	20,485	1,286,257	109,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,891	25,603	836,562	71,454	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	122	2,433	4,484	140,365	11,989	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	2,315	0	4,220	658,778	56,269	90.00
90.01	09001	OB CLINIC	1,382	0	1,318	204,151	17,437	90.01
90.02	09002	SPECIALTY CLINIC	33	0	57	663	57	90.02
91.00	09100	EMERGENCY	6,071	24,222	28,387	1,921,994	164,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,294	0	7,256	766,846	65,499	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	197,678	269,223	496,148	29,470,207	2,317,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,090	1,289	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	2	0	0	4,990	426	192.02
192.03	19202	LEASED SPACE	44	0	0	161,547	13,798	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	9,269	792	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	16,762	16,762	1,432	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	13,407	1,145	194.02
194.03	07952	ANESTHESIA BILLNG	0	7,612	14,030	21,642	1,849	194.03
194.04	07953	SPECIALTY CLINIC	14	0	0	933	80	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	441,663	0	194.06
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)	197,738	276,835	526,940	30,155,510	2,338,255	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,526,651					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,965	196,751				8.00
9.00	00900	HOUSEKEEPING	24,338	17,786	654,211			9.00
10.00	01000	DIETARY	55,368	1,069	36,847	1,058,235		10.00
11.00	01100	CAFETERIA	36,061	0	14,037	708,732	824,957	11.00
13.00	01300	NURSING ADMINISTRATION	15,314	0	0	0	15,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,932	0	0	0	0	14.00
15.00	01500	PHARMACY	22,424	0	3,339	0	12,528	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,323	0	3,905	0	51,620	16.00
17.00	01700	SOCIAL SERVICE	6,144	0	3,509	0	12,024	17.00
18.00	01080	INSERVICE EDUCATION	16,882	0	0	0	6,993	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	207,707	40,019	166,121	88,394	154,204	30.00
43.00	04300	NURSERY	4,193	0	906	0	11,471	43.00
44.00	04400	SKILLED NURSING FACILITY	267,451	62,601	141,274	261,109	125,376	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,210	28,690	119,426	0	122,005	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,878	0	0	0	2,214	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,876	14,616	16,018	0	57,053	54.00
60.00	06000	LABORATORY	42,515	0	6,169	0	62,336	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,404	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	3,099	0	0	0	1,560	64.00
66.00	06600	PHYSICAL THERAPY	140,707	13,879	18,338	0	93,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,563	0	4,981	0	26,917	67.00
68.00	06800	SPEECH PATHOLOGY	9,298	0	0	0	5,182	68.00
69.00	06900	ELECTROCARDIOLOGY	18,851	0	8,207	0	19,219	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,829	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	11,540	1,262	14,150	0	4,931	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	41,457	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	453	0	0	90.02
91.00	09100	EMERGENCY	109,113	16,829	10,924	0	39,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	18,377	0	3,509	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,507,819	196,751	572,113	1,058,235	824,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,972	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	82,098	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	8,860	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,526,651	196,751	654,211	1,058,235	824,957	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	427,965					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,703				14.00
15.00	01500	PHARMACY	11,438	0	504,198			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	736,823		16.00
17.00	01700	SOCIAL SERVICE	10,978	0	0	0	218,386	17.00
18.00	01080	INSERVICE EDUCATION	6,385	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,786	0	0	39,523	96,844	30.00
43.00	04300	NURSERY	10,473	0	0	4,062	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	9,359	109,277	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	111,389	0	0	157,464	3,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,021	0	0	3,970	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	145,515	0	54.00
60.00	06000	LABORATORY	56,912	0	0	78,871	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,695	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	33,297	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	46,811	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,876	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,353	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	26,184	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	59,703	0	3,629	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,696	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	504,198	37,116	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	6,501	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	6,118	299	90.00
90.01	09001	OB CLINIC	0	0	0	1,910	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	83	0	90.02
91.00	09100	EMERGENCY	36,380	0	0	41,152	3,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	41,203	0	0	0	4,955	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	427,965	59,703	504,198	692,185	218,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	24,299	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	20,339	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	427,965	59,703	504,198	736,823	218,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	223,656					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,544	4,197,856	0	4,197,856		30.00
43.00	04300	NURSERY	1,186	264,904	0	264,904		43.00
44.00	04400	SKILLED NURSING FACILITY	7,568	2,745,040	0	2,745,040		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,969	4,827,670	0	4,827,670		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,160	60,044	0	60,044		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,503	3,516,880	0	3,516,880		54.00
60.00	06000	LABORATORY	23,037	2,219,823	0	2,219,823		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	787	130,725	0	130,725		62.00
64.00	06400	INTRAVENOUS THERAPY	9,725	142,099	0	142,099		64.00
66.00	06600	PHYSICAL THERAPY	13,673	2,182,196	0	2,182,196		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,637	736,874	0	736,874		67.00
68.00	06800	SPEECH PATHOLOGY	687	145,069	0	145,069		68.00
69.00	06900	ELECTROCARDIOLOGY	7,861	717,982	0	717,982		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,060	68,583	0	68,583		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,674	1,438,320	0	1,438,320		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,841	1,460,171	0	1,460,171		73.00
76.00	03022	ACUPUNCTURE	0	0	0	0		76.00
76.01	03020	SLEEP LAB	1,899	192,637	0	192,637		76.01
76.02	03021	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	721,464	0	721,464		90.00
90.01	09001	OB CLINIC	0	264,955	0	264,955		90.01
90.02	09002	SPECIALTY CLINIC	0	1,256	0	1,256		90.02
91.00	09100	EMERGENCY	18,904	2,362,950	0	2,362,950		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	900,389	0	900,389		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	217,715	29,297,887	0	29,297,887		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,351	0	26,351		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.02	19201	ORTHO CLINIC	0	5,416	0	5,416		192.02
192.03	19202	LEASED SPACE	0	257,443	0	257,443		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	10,061	0	10,061		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	42,493	0	42,493		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	23,412	0	23,412		194.02
194.03	07952	ANESTHESIA BILLNG	5,941	49,771	0	49,771		194.03
194.04	07953	SPECIALTY CLINIC	0	1,013	0	1,013		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	441,663	0	441,663		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part I Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		18.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	223,656	30,155,510	0	30,155,510		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,835	0	15,835	15,835	4.00
5.01	00520	DATA PROCESSING	0	65,877	134,646	200,523	485	5.01
5.02	00530	PURCHASING RECEIVING AND STORES	0	71,063	0	71,063	146	5.02
5.03	00540	ADMITTING	0	28,387	12,742	41,129	204	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	26,456	930	27,386	363	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	75,229	20,945	96,174	648	5.05
7.00	00700	OPERATION OF PLANT	0	196,086	21,717	217,803	260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,131	1,433	22,564	44	8.00
9.00	00900	HOUSEKEEPING	0	36,828	0	36,828	440	9.00
10.00	01000	DIETARY	0	83,781	6,116	89,897	578	10.00
11.00	01100	CAFETERIA	0	54,566	0	54,566	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,173	1,047	24,220	332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,924	0	2,924	0	14.00
15.00	01500	PHARMACY	0	33,932	3,660	37,592	214	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,318	4,234	42,552	451	16.00
17.00	01700	SOCIAL SERVICE	0	9,297	0	9,297	165	17.00
18.00	01080	INSERVICE EDUCATION	0	25,545	4,598	30,143	126	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	314,295	45,208	359,503	2,343	30.00
43.00	04300	NURSERY	0	6,345	6,173	12,518	205	43.00
44.00	04400	SKILLED NURSING FACILITY	0	404,697	35,162	439,859	1,110	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	331,702	176,402	508,104	1,796	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,841	0	2,841	40	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	205,604	354,472	560,076	863	54.00
60.00	06000	LABORATORY	0	64,332	24,162	88,494	803	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,124	0	2,124	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	4,690	0	4,690	43	64.00
66.00	06600	PHYSICAL THERAPY	0	212,914	28,617	241,531	1,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,050	0	81,050	473	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,069	0	14,069	95	68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,525	28,845	57,370	342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,793	0	5,793	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	17,462	3,845	21,307	70	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	42,642	42,642	265	90.00
90.01	09001	OB CLINIC	0	62,732	8,476	71,208	95	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	165,106	18,991	184,097	694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	27,807	258	28,065	656	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,760,516	985,321	3,745,837	15,825	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,090	0	15,090	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	2,424	2,424	0	192.02
192.03	19202	LEASED SPACE	0	82,236	8,541	90,777	9	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	9,269	0	9,269	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	13,407	0	13,407	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	1	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	441,663	0	441,663	0	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	0	3,322,181	996,286	4,318,467	15,835	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING	201,008					5.01
5.02	00530	PURCHASING RECEIVING AND STORES	2,445	73,654				5.02
5.03	00540	ADMITTING	4,922	52	46,307			5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	223	0	27,972		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	32,741	475	0	0	130,038	5.05
7.00	00700	OPERATION OF PLANT	0	1,343	0	0	6,681	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	42	0	0	800	8.00
9.00	00900	HOUSEKEEPING	847	1,456	0	0	2,679	9.00
10.00	01000	DIETARY	2,086	829	0	0	4,223	10.00
11.00	01100	CAFETERIA	1,336	0	0	0	289	11.00
13.00	01300	NURSING ADMINISTRATION	1,581	108	0	0	1,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	934	0	0	253	14.00
15.00	01500	PHARMACY	6,877	62	0	0	1,989	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,929	119	0	0	2,871	16.00
17.00	01700	SOCIAL SERVICE	750	2	0	0	813	17.00
18.00	01080	INSERVICE EDUCATION	0	57	0	0	846	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,246	3,360	2,474	1,446	14,235	30.00
43.00	04300	NURSERY	0	18	254	149	1,018	43.00
44.00	04400	SKILLED NURSING FACILITY	6,291	910	0	948	7,707	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,928	19,537	11,131	5,787	17,567	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	249	145	214	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,323	4,046	9,110	5,323	13,589	54.00
60.00	06000	LABORATORY	4,302	9,600	4,938	2,885	8,534	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	169	99	551	62.00
64.00	06400	INTRAVENOUS THERAPY	0	108	2,084	1,218	413	64.00
66.00	06600	PHYSICAL THERAPY	8,083	441	2,930	1,712	8,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	945	106	994	581	2,761	67.00
68.00	06800	SPEECH PATHOLOGY	652	4	147	86	558	68.00
69.00	06900	ELECTROCARDIOLOGY	3,357	218	1,685	958	2,791	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	227	133	18	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,403	1,859	1,086	6,110	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,324	1,358	3,974	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	46	407	238	667	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	40,190	862	0	224	3,129	90.00
90.01	09001	OB CLINIC	0	515	0	70	970	90.01
90.02	09002	SPECIALTY CLINIC	0	12	0	3	3	90.02
91.00	09100	EMERGENCY	14,374	2,261	4,052	1,505	9,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,803	482	0	385	3,643	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,008	73,631	45,034	26,339	128,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	72	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	1	0	0	24	192.02
192.03	19202	LEASED SPACE	0	17	0	0	767	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	44	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	889	80	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	64	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,273	744	103	194.03
194.04	07953	SPECIALTY CLINIC	0	5	0	0	4	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	201,008	73,654	46,307	27,972	130,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	226,087					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,068	25,518				8.00
9.00	00900	HOUSEKEEPING	3,604	2,307	48,161			9.00
10.00	01000	DIETARY	8,200	139	2,713	108,665		10.00
11.00	01100	CAFETERIA	5,340	0	1,033	72,776	135,340	11.00
13.00	01300	NURSING ADMINISTRATION	2,268	0	0	0	2,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	286	0	0	0	0	14.00
15.00	01500	PHARMACY	3,321	0	246	0	2,055	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,750	0	288	0	8,469	16.00
17.00	01700	SOCIAL SERVICE	910	0	258	0	1,973	17.00
18.00	01080	INSERVICE EDUCATION	2,500	0	0	0	1,147	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,760	5,190	12,229	9,077	25,298	30.00
43.00	04300	NURSERY	621	0	67	0	1,882	43.00
44.00	04400	SKILLED NURSING FACILITY	39,607	8,118	10,400	26,812	20,569	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,464	3,721	8,792	0	20,016	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	278	0	0	0	363	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,122	1,896	1,179	0	9,360	54.00
60.00	06000	LABORATORY	6,296	0	454	0	10,227	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	208	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	459	0	0	0	256	64.00
66.00	06600	PHYSICAL THERAPY	20,838	1,800	1,350	0	15,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,932	0	367	0	4,416	67.00
68.00	06800	SPEECH PATHOLOGY	1,377	0	0	0	850	68.00
69.00	06900	ELECTROCARDIOLOGY	2,792	0	604	0	3,153	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	567	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	1,709	164	1,042	0	809	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	6,140	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	33	0	0	90.02
91.00	09100	EMERGENCY	16,159	2,183	804	0	6,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,722	0	258	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	223,298	25,518	42,117	108,665	135,340	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,477	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	6,044	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	1,312	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	226,087	25,518	48,161	108,665	135,340	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	32,797					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,397				14.00
15.00	01500	PHARMACY	877	0	53,233			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	70,429		16.00
17.00	01700	SOCIAL SERVICE	841	0	0	0	15,009	17.00
18.00	01080	INSERVICE EDUCATION	489	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,789	0	0	3,776	6,656	30.00
43.00	04300	NURSERY	803	0	0	388	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	894	7,509	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,536	0	0	15,076	232	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	155	0	0	379	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,903	0	54.00
60.00	06000	LABORATORY	4,361	0	0	7,535	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	258	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,181	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,472	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,517	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,502	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,397	0	347	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,837	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	53,233	3,546	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	621	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	584	21	90.00
90.01	09001	OB CLINIC	0	0	0	183	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	8	0	90.02
91.00	09100	EMERGENCY	2,788	0	0	3,932	250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,158	0	0	0	341	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,797	4,397	53,233	66,164	15,009	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	2,322	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	1,943	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	32,797	4,397	53,233	70,429	15,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	35,308					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,823	522,205	0	522,205		30.00
43.00	04300	NURSERY	187	18,110	0	18,110		43.00
44.00	04400	SKILLED NURSING FACILITY	1,195	571,929	0	571,929		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,192	675,879	0	675,879		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	183	4,847	0	4,847		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,713	652,503	0	652,503		54.00
60.00	06000	LABORATORY	3,639	152,068	0	152,068		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	124	3,533	0	3,533		62.00
64.00	06400	INTRAVENOUS THERAPY	1,536	13,988	0	13,988		64.00
66.00	06600	PHYSICAL THERAPY	2,160	310,320	0	310,320		66.00
67.00	06700	OCCUPATIONAL THERAPY	732	101,874	0	101,874		67.00
68.00	06800	SPEECH PATHOLOGY	109	18,172	0	18,172		68.00
69.00	06900	ELECTROCARDIOLOGY	1,242	77,014	0	77,014		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	167	5,289	0	5,289		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,370	45,025	0	45,025		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,712	66,147	0	66,147		73.00
76.00	03022	ACUPUNCTURE	0	0	0	0		76.00
76.01	03020	SLEEP LAB	300	27,380	0	27,380		76.01
76.02	03021	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	87,917	0	87,917		90.00
90.01	09001	OB CLINIC	0	79,181	0	79,181		90.01
90.02	09002	SPECIALTY CLINIC	0	59	0	59		90.02
91.00	09100	EMERGENCY	2,986	251,751	0	251,751		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	42,513	0	42,513		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,370	3,727,704	0	3,727,704		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,639	0	16,639		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.02	19201	ORTHO CLINIC	0	2,449	0	2,449		192.02
192.03	19202	LEASED SPACE	0	97,614	0	97,614		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	9,313	0	9,313		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	3,291	0	3,291		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	14,783	0	14,783		194.02
194.03	07952	ANESTHESIA BILLNG	938	5,001	0	5,001		194.03
194.04	07953	SPECIALTY CLINIC	0	10	0	10		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	441,663	0	441,663		194.06
200.00		Cross Foot Adjustments	0	0	0	0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B Part II Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		18.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	35,308	4,318,467	0	4,318,467		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	120,427					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		953,448				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	574	0	11,683,647			4.00
5.01	00520	DATA PROCESSING	2,388	128,856	357,872	154,176		5.01
5.02	00530	PURCHASING RECEIVING AND STORES	2,576	0	107,941	1,875	3,423,281	5.02
5.03	00540	ADMITTING	1,029	12,194	150,536	3,775	2,427	5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	959	890	268,236	0	10,344	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	2,727	20,044	478,191	25,113	22,080	5.05
7.00	00700	OPERATION OF PLANT	7,108	20,783	191,650	0	62,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	766	1,371	32,206	0	1,951	8.00
9.00	00900	HOUSEKEEPING	1,335	0	324,634	650	67,650	9.00
10.00	01000	DIETARY	3,037	5,853	426,630	1,600	38,549	10.00
11.00	01100	CAFETERIA	1,978	0	0	1,025	0	11.00
13.00	01300	NURSING ADMINISTRATION	840	1,002	244,696	1,213	5,015	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	0	0	0	43,393	14.00
15.00	01500	PHARMACY	1,230	3,503	158,167	5,275	2,894	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,389	4,052	332,790	9,150	5,548	16.00
17.00	01700	SOCIAL SERVICE	337	0	121,501	575	101	17.00
18.00	01080	INSERVICE EDUCATION	926	4,400	92,767	0	2,656	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,393	43,264	1,726,636	25,500	156,168	30.00
43.00	04300	NURSERY	230	5,908	151,329	0	823	43.00
44.00	04400	SKILLED NURSING FACILITY	14,670	33,650	819,439	4,825	42,315	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,024	168,817	1,325,222	11,450	908,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103	0	29,260	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,453	339,231	637,118	4,850	188,060	54.00
60.00	06000	LABORATORY	2,332	23,123	592,578	3,300	446,191	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	77	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	170	0	32,071	0	5,042	64.00
66.00	06600	PHYSICAL THERAPY	7,718	27,387	1,089,637	6,200	20,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,938	0	349,278	725	4,910	67.00
68.00	06800	SPEECH PATHOLOGY	510	0	70,114	500	209	68.00
69.00	06900	ELECTROCARDIOLOGY	1,034	27,605	252,354	2,575	10,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	210	0	0	0	1,180,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	633	3,680	51,454	0	2,115	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	40,808	195,315	30,825	40,076	90.00
90.01	09001	OB CLINIC	2,274	8,112	70,389	0	23,917	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	573	90.02
91.00	09100	EMERGENCY	5,985	18,174	512,356	11,025	105,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,008	247	484,283	2,150	22,406	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,067	942,954	11,676,650	154,176	3,422,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	547	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	2,320	103	0	30	192.02
192.03	19202	LEASED SPACE	2,981	8,174	6,368	0	770	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	336	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	486	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	526	0	238	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	16,010	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
		1.00	2.00	4.00	5.01	5.02	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,322,181	996,286	3,448,237	956,255	197,738	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.586679	1.044930	0.295134	6.202360	0.057763	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			15,835	201,008	73,654	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001355	1.303757	0.021516	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING	67,307,935					5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	69,509,927				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-2,338,255	27,375,592		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,406,515	83,739	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	168,402	766	8.00
9.00	00900	HOUSEKEEPING	0	0	0	563,920	1,335	9.00
10.00	01000	DIETARY	0	0	0	889,017	3,037	10.00
11.00	01100	CAFETERIA	0	0	0	60,923	1,978	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	365,856	840	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	53,225	106	14.00
15.00	01500	PHARMACY	0	0	0	418,706	1,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	604,355	1,389	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	171,115	337	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	178,177	926	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,596,298	3,596,298	0	2,996,750	11,393	30.00
43.00	04300	NURSERY	369,591	369,591	0	214,308	230	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,357,647	0	1,622,445	14,670	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,180,723	14,329,997	0	3,698,267	12,024	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	361,219	361,219	0	44,961	103	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,240,679	13,240,679	0	2,860,935	7,453	54.00
60.00	06000	LABORATORY	7,176,654	7,176,654	0	1,796,534	2,332	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	245,239	245,239	0	115,936	77	62.00
64.00	06400	INTRAVENOUS THERAPY	3,029,715	3,029,715	0	86,988	170	64.00
66.00	06600	PHYSICAL THERAPY	4,259,378	4,259,378	0	1,708,894	7,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,444,590	1,444,590	0	581,253	2,938	67.00
68.00	06800	SPEECH PATHOLOGY	214,068	214,068	0	117,512	510	68.00
69.00	06900	ELECTROCARDIOLOGY	2,448,941	2,382,511	0	587,481	1,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	330,223	330,223	0	3,861	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,702,088	2,702,088	0	1,286,257	210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,377,229	3,377,229	0	836,562	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	591,497	591,497	0	140,365	633	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	556,651	0	658,778	0	90.00
90.01	09001	OB CLINIC	0	173,819	0	204,151	2,274	90.01
90.02	09002	SPECIALTY CLINIC	0	7,517	0	663	0	90.02
91.00	09100	EMERGENCY	5,889,077	3,744,485	0	1,921,994	5,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	957,084	0	766,846	1,008	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,457,209	65,448,179	-2,338,255	27,131,952	82,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,090	547	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	4,990	0	192.02
192.03	19202	LEASED SPACE	0	0	0	161,547	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	9,269	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	2,211,022	0	16,762	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	13,407	486	194.02
194.03	07952	ANESTHESIA BILLNG	1,850,726	1,850,726	0	21,642	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	933	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-441,663	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	276,835	526,940		2,338,255	1,526,651	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004113	0.007581		0.085414	18.231063	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,307	27,972		130,038	226,087	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000688	0.000402		0.004750	2.699901	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	272,747					8.00
9.00	00900	HOUSEKEEPING	24,656	577,925				9.00
10.00	01000	DIETARY	1,482	32,550	161,668			10.00
11.00	01100	CAFETERIA	0	12,400	108,274	16,397		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	309	9,317	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,950	0	249	249	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,450	0	1,026	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,100	0	239	239	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	139	139	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,476	146,750	13,504	3,065	3,065	30.00
43.00	04300	NURSERY	0	800	0	228	228	43.00
44.00	04400	SKILLED NURSING FACILITY	86,780	124,800	39,890	2,492	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,772	105,500	0	2,425	2,425	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	44	44	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,262	14,150	0	1,134	0	54.00
60.00	06000	LABORATORY	0	5,450	0	1,239	1,239	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	31	0	64.00
66.00	06600	PHYSICAL THERAPY	19,240	16,200	0	1,867	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,400	0	535	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,250	0	382	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	1,750	12,500	0	98	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	400	0	0	0	90.02
91.00	09100	EMERGENCY	23,329	9,650	0	792	792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	3,100	0	0	897	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	272,747	505,400	161,668	16,397	9,317	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	72,525	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	196,751	654,211	1,058,235	824,957	427,965	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
		8.00	9.00	10.00	11.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.721368	1.132000	6.545730	50.311459	45.933777	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	25,518	48,161	108,665	135,340	32,797	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.093559	0.083334	0.672149	8.253949	3.520125	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)	
			14.00	15.00	16.00	17.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00520	DATA PROCESSING						5.01
5.02	00530	PURCHASING RECEIVING AND STORES						5.02
5.03	00540	ADMITTING						5.03
5.04	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	67,046,824			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	83,955		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	69,665,582	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,596,298	37,230	3,596,298	30.00
43.00	04300	NURSERY	0	0	369,591	0	369,591	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	851,628	42,010	2,357,647	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,329,997	1,295	16,180,723	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	361,219	0	361,219	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	13,240,679	0	13,240,679	54.00
60.00	06000	LABORATORY	0	0	7,176,654	0	7,176,654	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	245,239	0	245,239	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,029,715	0	3,029,715	64.00
66.00	06600	PHYSICAL THERAPY	0	0	4,259,378	0	4,259,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,444,590	0	1,444,590	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	214,068	0	214,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,382,511	0	2,448,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	330,223	0	330,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,702,088	0	2,702,088	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	3,377,229	0	3,377,229	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	591,497	0	591,497	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	556,651	115	0	90.00
90.01	09001	OB CLINIC	0	0	173,819	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	7,517	0	0	90.02
91.00	09100	EMERGENCY	0	0	3,744,485	1,400	5,889,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,905	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	62,985,076	83,955	67,814,856	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19201	ORTHO CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	2,211,022	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,850,726	0	1,850,726	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet B-1 | Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)	
		14.00	15.00	16.00	17.00	18.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	59,703	504,198	736,823	218,386	223,656	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	597.030000	5,041.980000	0.010990	2.601227	0.003210	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,397	53,233	70,429	15,009	35,308	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	43.970000	532.330000	0.001050	0.178774	0.000507	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,197,856		4,197,856	0	4,197,856	30.00
43.00	04300	NURSERY	264,904		264,904	0	264,904	43.00
44.00	04400	SKILLED NURSING FACILITY	2,745,040		2,745,040	0	2,745,040	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,827,670		4,827,670	0	4,827,670	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,044		60,044	0	60,044	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516,880		3,516,880	0	3,516,880	54.00
60.00	06000	LABORATORY	2,219,823		2,219,823	0	2,219,823	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	130,725		130,725	0	130,725	62.00
64.00	06400	INTRAVENOUS THERAPY	142,099		142,099	0	142,099	64.00
66.00	06600	PHYSICAL THERAPY	2,182,196	0	2,182,196	0	2,182,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	736,874	0	736,874	0	736,874	67.00
68.00	06800	SPEECH PATHOLOGY	145,069	0	145,069	0	145,069	68.00
69.00	06900	ELECTROCARDIOLOGY	717,982		717,982	0	717,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,583		68,583	0	68,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,438,320		1,438,320	0	1,438,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,460,171		1,460,171	0	1,460,171	73.00
76.00	03022	ACUPUNCTURE	0		0	0	0	76.00
76.01	03020	SLEEP LAB	192,637		192,637	0	192,637	76.01
76.02	03021	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	721,464		721,464	0	721,464	90.00
90.01	09001	OB CLINIC	264,955		264,955	0	264,955	90.01
90.02	09002	SPECIALTY CLINIC	1,256		1,256	0	1,256	90.02
91.00	09100	EMERGENCY	2,362,950		2,362,950	0	2,362,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	573,146		573,146		573,146	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	900,389		900,389		900,389	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,871,033	0	29,871,033	0	29,871,033	200.00
201.00		Less Observation Beds	573,146		573,146		573,146	201.00
202.00		Total (see instructions)	29,297,887	0	29,297,887	0	29,297,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,026,994		3,026,994			30.00
43.00	04300	NURSERY	369,591		369,591			43.00
44.00	04400	SKILLED NURSING FACILITY	2,357,647		2,357,647			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,183,359	10,146,637	14,329,996	0.336893	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	297,406	63,813	361,219	0.166226	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,678	12,570,001	13,240,679	0.265612	0.000000	54.00
60.00	06000	LABORATORY	983,420	6,193,234	7,176,654	0.309312	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	159,619	85,620	245,239	0.533051	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,118,811	910,904	3,029,715	0.046902	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	649,017	3,610,361	4,259,378	0.512327	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	410,432	1,034,158	1,444,590	0.510092	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	89,740	124,328	214,068	0.677677	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	141,464	2,241,047	2,382,511	0.301355	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	250,134	80,089	330,223	0.207687	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,075,570	626,519	2,702,089	0.532299	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,358,559	2,018,670	3,377,229	0.432358	0.000000	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03020	SLEEP LAB	0	591,497	591,497	0.325677	0.000000	76.01
76.02	03021	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	556,651	556,651	1.296080	0.000000	90.00
90.01	09001	OB CLINIC	64,595	109,224	173,819	1.524316	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	7,517	7,517	0.167088	0.000000	90.02
91.00	09100	EMERGENCY	91,717	3,652,768	3,744,485	0.631048	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,194	539,111	569,305	1.006747	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	957,084	957,084			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,328,947	46,119,233	65,448,180			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,328,947	46,119,233	65,448,180			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03022	ACUPUNCTURE	0.000000		76.00
76.01	03020	SLEEP LAB	0.000000		76.01
76.02	03021	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,197,856		4,197,856	0	4,197,856	30.00
43.00	04300	NURSERY	264,904		264,904	0	264,904	43.00
44.00	04400	SKILLED NURSING FACILITY	2,745,040		2,745,040	0	2,745,040	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,827,670		4,827,670	0	4,827,670	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,044		60,044	0	60,044	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516,880		3,516,880	0	3,516,880	54.00
60.00	06000	LABORATORY	2,219,823		2,219,823	0	2,219,823	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	130,725		130,725	0	130,725	62.00
64.00	06400	INTRAVENOUS THERAPY	142,099		142,099	0	142,099	64.00
66.00	06600	PHYSICAL THERAPY	2,182,196	0	2,182,196	0	2,182,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	736,874	0	736,874	0	736,874	67.00
68.00	06800	SPEECH PATHOLOGY	145,069	0	145,069	0	145,069	68.00
69.00	06900	ELECTROCARDIOLOGY	717,982		717,982	0	717,982	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,583		68,583	0	68,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,438,320		1,438,320	0	1,438,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,460,171		1,460,171	0	1,460,171	73.00
76.00	03022	ACUPUNCTURE	0		0	0	0	76.00
76.01	03020	SLEEP LAB	192,637		192,637	0	192,637	76.01
76.02	03021	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	721,464		721,464	0	721,464	90.00
90.01	09001	OB CLINIC	264,955		264,955	0	264,955	90.01
90.02	09002	SPECIALTY CLINIC	1,256		1,256	0	1,256	90.02
91.00	09100	EMERGENCY	2,362,950		2,362,950	0	2,362,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	573,146		573,146		573,146	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	900,389		900,389		900,389	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,871,033	0	29,871,033	0	29,871,033	200.00
201.00		Less Observation Beds	573,146		573,146		573,146	201.00
202.00		Total (see instructions)	29,297,887	0	29,297,887	0	29,297,887	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,026,994		3,026,994			30.00
43.00	04300	NURSERY	369,591		369,591			43.00
44.00	04400	SKILLED NURSING FACILITY	2,357,647		2,357,647			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,183,359	10,146,637	14,329,996	0.336893	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	297,406	63,813	361,219	0.166226	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,678	12,570,001	13,240,679	0.265612	0.000000	54.00
60.00	06000	LABORATORY	983,420	6,193,234	7,176,654	0.309312	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	159,619	85,620	245,239	0.533051	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,118,811	910,904	3,029,715	0.046902	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	649,017	3,610,361	4,259,378	0.512327	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	410,432	1,034,158	1,444,590	0.510092	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	89,740	124,328	214,068	0.677677	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	141,464	2,241,047	2,382,511	0.301355	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	250,134	80,089	330,223	0.207687	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,075,570	626,519	2,702,089	0.532299	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,358,559	2,018,670	3,377,229	0.432358	0.000000	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03020	SLEEP LAB	0	591,497	591,497	0.325677	0.000000	76.01
76.02	03021	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	556,651	556,651	1.296080	0.000000	90.00
90.01	09001	OB CLINIC	64,595	109,224	173,819	1.524316	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	7,517	7,517	0.167088	0.000000	90.02
91.00	09100	EMERGENCY	91,717	3,652,768	3,744,485	0.631048	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,194	539,111	569,305	1.006747	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	957,084	957,084			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,328,947	46,119,233	65,448,180			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	19,328,947	46,119,233	65,448,180			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet C Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03022	ACUPUNCTURE	0.000000		76.00
76.01	03020	SLEEP LAB	0.000000		76.01
76.02	03021	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part II Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	675,879	14,329,996	0.047165	1,736,768	81,915	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,847	361,219	0.013418	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,503	13,240,679	0.049280	301,949	14,880	54.00
60.00	06000	LABORATORY	152,068	7,176,654	0.021189	364,180	7,717	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,533	245,239	0.014406	96,555	1,391	62.00
64.00	06400	INTRAVENOUS THERAPY	13,988	3,029,715	0.004617	864,074	3,989	64.00
66.00	06600	PHYSICAL THERAPY	310,320	4,259,378	0.072856	135,152	9,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,874	1,444,590	0.070521	79,593	5,613	67.00
68.00	06800	SPEECH PATHOLOGY	18,172	214,068	0.084889	17,101	1,452	68.00
69.00	06900	ELECTROCARDIOLOGY	77,014	2,382,511	0.032325	93,333	3,017	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,289	330,223	0.016016	184,128	2,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,025	2,702,089	0.016663	1,076,227	17,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,147	3,377,229	0.019586	513,391	10,055	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	27,380	591,497	0.046289	0	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	87,917	556,651	0.157939	0	0	90.00
90.01	09001	OB CLINIC	79,181	173,819	0.455537	0	0	90.01
90.02	09002	SPECIALTY CLINIC	59	7,517	0.007849	0	0	90.02
91.00	09100	EMERGENCY	251,751	3,744,485	0.067232	1,578	106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,780	569,305	0.154188	7,604	1,172	92.00
200.00		Total (lines 50-199)	2,660,727	58,736,864		5,471,633	162,036	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,329,996	0.000000	0.000000	1,736,768	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	361,219	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,240,679	0.000000	0.000000	301,949	54.00
60.00	06000	LABORATORY	0	7,176,654	0.000000	0.000000	364,180	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	245,239	0.000000	0.000000	96,555	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,029,715	0.000000	0.000000	864,074	64.00
66.00	06600	PHYSICAL THERAPY	0	4,259,378	0.000000	0.000000	135,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,444,590	0.000000	0.000000	79,593	67.00
68.00	06800	SPEECH PATHOLOGY	0	214,068	0.000000	0.000000	17,101	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,382,511	0.000000	0.000000	93,333	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	330,223	0.000000	0.000000	184,128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,702,089	0.000000	0.000000	1,076,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,377,229	0.000000	0.000000	513,391	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	591,497	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	556,651	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	173,819	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	7,517	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	3,744,485	0.000000	0.000000	1,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	569,305	0.000000	0.000000	7,604	92.00
200.00		Total (lines 50-199)	0	58,736,864			5,471,633	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.336893	0	3,164,452	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	0	4,049,747	0	0	54.00
60.00	06000	LABORATORY	0.309312	0	2,470,343	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	0	55,125	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	0	380,007	2,175	0	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	0	1,002,424	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	0	205,015	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	0	30,961	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	0	1,210,031	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	0	30,901	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	0	182,352	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	0	1,002,109	5,817	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	186,580	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.296080	0	65,682	750	0	90.00
90.01	09001	OB CLINIC	1.524316	0	3,824	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	2,164	0	0	90.02
91.00	09100	EMERGENCY	0.631048	0	1,229,212	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	0	277,179	0	0	92.00
200.00		Subtotal (see instructions)		0	15,548,108	8,742	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	15,548,108	8,742	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,066,082	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,075,661	0		54.00
60.00	06000	LABORATORY	764,107	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	29,384	0		62.00
64.00	06400	INTRAVENOUS THERAPY	17,823	102		64.00
66.00	06600	PHYSICAL THERAPY	513,569	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	104,577	0		67.00
68.00	06800	SPEECH PATHOLOGY	20,982	0		68.00
69.00	06900	ELECTROCARDIOLOGY	364,649	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,418	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	97,066	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	433,270	2,515		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	60,765	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	85,129	972		90.00
90.01	09001	OB CLINIC	5,829	0		90.01
90.02	09002	SPECIALTY CLINIC	362	0		90.02
91.00	09100	EMERGENCY	775,692	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,049	0		92.00
200.00		Subtotal (see instructions)	5,700,414	3,589		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,700,414	3,589		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.336893	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	0	0	0	0	54.00
60.00	06000	LABORATORY	0.309312	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	0	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.296080	0	0	0	0	90.00
90.01	09001	OB CLINIC	1.524316	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.631048	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03022	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0	0	0	0	0	76.01
76.02	03021	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,329,996	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	361,219	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,240,679	0.000000	0.000000	7,077	54.00
60.00	06000	LABORATORY	0	7,176,654	0.000000	0.000000	11,675	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	245,239	0.000000	0.000000	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,029,715	0.000000	0.000000	20,908	64.00
66.00	06600	PHYSICAL THERAPY	0	4,259,378	0.000000	0.000000	223,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,444,590	0.000000	0.000000	148,367	67.00
68.00	06800	SPEECH PATHOLOGY	0	214,068	0.000000	0.000000	44,737	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,382,511	0.000000	0.000000	175	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	330,223	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,702,089	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,377,229	0.000000	0.000000	89,167	73.00
76.00	03022	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03020	SLEEP LAB	0	591,497	0.000000	0.000000	0	76.01
76.02	03021	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	556,651	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	173,819	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	7,517	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	3,744,485	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	569,305	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	58,736,864			545,615	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part IV | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03022	ACUPUNCTURE	0	0	0		76.00
76.01	03020	SLEEP LAB	0	0	0		76.01
76.02	03021	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.336893	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	0	0	0	0	54.00
60.00	06000	LABORATORY	0.309312	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	0	0	70	0	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	0	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.296080	0	0	0	0	90.00
90.01	09001	OB CLINIC	1.524316	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.631048	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	70	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	70	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D Part V Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30		73.00
76.00	03022	ACUPUNCTURE	0	0		76.00
76.01	03020	SLEEP LAB	0	0		76.01
76.02	03021	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
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	30		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	30		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-1 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,887	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,968	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,301	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	459	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)	458	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	1	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,551	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)	401	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)	401	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	121.01	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	121.01	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,197,856	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)	121	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)	121	25.00
26.00	Total swing-bed cost (see instructions)	788,211	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,409,645	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,409,645	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)	859.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,332,759	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)	1,332,759	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-1 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,861,240	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,193,999	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)	344,575	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	344,575	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	689,150	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)	667	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	859.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	573,146	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-1 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	522,205	3,409,645	0.153155	573,146	87,780	90.00
91.00	Nursing School cost	0	3,409,645	0.000000	573,146	0	91.00
92.00	Allied health cost	0	3,409,645	0.000000	573,146	0	92.00
93.00	All other Medical Education	0	3,409,645	0.000000	573,146	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2013 To 05/31/2014	Worksheet D-1 Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,084	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,084	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,084	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	926	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,745,040	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,745,040	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,745,040	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-1 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,745,040	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	209.80	71.00
72.00	Program routine service cost (line 9 x line 71)	194,275	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	194,275	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	194,275	83.00
84.00	Program inpatient ancillary services (see instructions)	265,585	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	459,860	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2013 To 05/31/2014	Worksheet D-1 Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-3 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,255,131		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.336893	1,736,768	585,105	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	301,949	80,201	54.00
60.00	06000	LABORATORY	0.309312	364,180	112,645	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	96,555	51,469	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	864,074	40,527	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	135,152	69,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	79,593	40,600	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	17,101	11,589	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	93,333	28,126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	184,128	38,241	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	1,076,227	572,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	513,391	221,969	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.296080	0	0	90.00
90.01	09001	OB CLINIC	1.524316	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	0	90.02
91.00	09100	EMERGENCY	0.631048	1,578	996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	7,604	7,655	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,471,633	1,861,240	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,471,633		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-3 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.336893	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	30,418	8,079	54.00
60.00	06000	LABORATORY	0.309312	54,006	16,705	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	10,474	5,583	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	98,459	4,618	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	165,158	84,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	107,884	55,031	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	23,466	15,902	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	3,841	1,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	7,869	1,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	121,469	52,518	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.296080	0	0	90.00
90.01	09001	OB CLINIC	1.524316	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	0	90.02
91.00	09100	EMERGENCY	0.631048	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		623,044	245,843	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)		623,044		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet D-3 | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.336893	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.166226	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265612	7,077	1,880	54.00
60.00	06000	LABORATORY	0.309312	11,675	3,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533051	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.046902	20,908	981	64.00
66.00	06600	PHYSICAL THERAPY	0.512327	223,509	114,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.510092	148,367	75,681	67.00
68.00	06800	SPEECH PATHOLOGY	0.677677	44,737	30,317	68.00
69.00	06900	ELECTROCARDIOLOGY	0.301355	175	53	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.207687	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.532299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.432358	89,167	38,552	73.00
76.00	03022	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03020	SLEEP LAB	0.325677	0	0	76.01
76.02	03021	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.296080	0	0	90.00
90.01	09001	OB CLINIC	1.524316	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.167088	0	0	90.02
91.00	09100	EMERGENCY	0.631048	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.006747	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		545,615	265,585	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)		545,615		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet E Part B Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,704,003	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,704,003	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,761,043	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)	58,158	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,578,839	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,124,046	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,124,046	30.00
31.00	Primary payer payments	641	31.00
32.00	Subtotal (line 30 minus line 31)	3,123,405	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)	185,105	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	162,892	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	117,194	36.00
37.00	Subtotal (see instructions)	3,286,297	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,286,297	40.00
40.01	Sequestration adjustment (see instructions)	65,726	40.01
41.00	Interim payments	3,224,269	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-3,698	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2013 To 05/31/2014	Worksheet E Part B Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	30	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	30	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	70	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)	70	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)	70	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	40	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)	30	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	30	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)	30	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	30	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	30	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	30	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	55	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-26	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,707,451		3,360,704	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/11/2013	15,536	05/20/2014	136,435	3.50
3.51		05/20/2014	100,857		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)		-116,393		-136,435	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,591,058		3,224,269	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		159,665		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3,698	6.02
7.00	Total Medicare program liability (see instructions)		2,750,723		3,220,571	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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 9/13/2014 2:33 pm

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		905,307		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	05/20/2014	18,509		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)		18,509		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)		923,816		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,290		0	6.02
7.00	Total Medicare program liability (see instructions)		908,526		0	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: 141319 | Component CCN: 145464 | Period: From 06/01/2013 To 05/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 9/13/2014 2:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		321,507		55	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		321,507		55	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		26	6.02
7.00	Total Medicare program liability (see instructions)		321,507		29	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: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet E-1 Part II Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,181	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,551	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	193	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,301	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	65,448,180	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	469,217	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141319 Component CCN: 14Z319	Period: From 06/01/2013 To 05/31/2014	Worksheet E-2 Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	696,042	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 6 and 7, line 202 for Part B) (For CAH, see instructions)	248,301	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	802	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)	944,343	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	944,343	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)	944,343	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,276	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)	927,067	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	927,067	0	19.00
19.01	Sequestration adjustment (see instructions)	18,541	0	19.01
20.00	Interim payments	923,816	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-15,290	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2013 To 05/31/2014	Worksheet E-3 Part V Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	3,193,999	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	3,193,999	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,225,939	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,225,939	19.00
20.00	Deductibles (exclude professional component)	471,606	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,754,333	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,754,333	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	59,690	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	52,527	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,624	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,806,860	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,806,860	30.00
30.01	Sequestration adjustment (see instructions)	56,137	30.01
31.00	Interim payments	2,591,058	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	159,665	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2013 To 05/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 9/13/2014 2:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	392,652	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	392,652	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	64,584	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	328,068	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	328,068	15.00
15.01	Sequestration adjustment (see instructions)	6,561	15.01
16.00	Interim payments	321,507	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet G | Date/Time Prepared: 9/13/2014 2:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,456,547	0	0	0	1.00
2.00	Temporary investments	983,483	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,525,852	0	0	0	4.00
5.00	Other receivable	1,453,570	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	802,727	0	0	0	7.00
8.00	Prepaid expenses	242,820	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	868,240	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,333,239	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,235,403	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,235,403	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,613,432	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	874,199	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,487,631	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,056,273	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	574,964	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,451,791	0	0	0	38.00
39.00	Payroll taxes payable	354,570	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,423,377	0	0	0	40.00
41.00	Deferred income	1,458,580	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	38,483	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,301,765	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,245,037	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	422,027	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	25,667,064	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	30,968,829	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,087,444				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,087,444	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,056,273	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet G-1 | Date/Time Prepared: 9/13/2014 2:33 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,697,115		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		734,186				2.00
3.00	Total (sum of line 1 and line 2)		29,431,301		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,431,301		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,431,301		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/13/2014 2:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,604,551		3,604,551	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,337,322		2,337,322	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,941,873		5,941,873	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,941,873		5,941,873	17.00
18.00	Ancillary services	13,180,246	37,062,917	50,243,163	18.00
19.00	Outpatient services	234,169	7,772,366	8,006,535	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		891,215	891,215	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	319,755	0	319,755	27.00
27.01	NRCC CLINICS	110,155	0	110,155	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,786,198	45,726,498	65,512,696	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,519,700		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	OTHER OP LTC	132			37.00
38.00	EDUCATION CONTRACTS	1,112			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		1,244		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,518,456		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet G-3 | Date/Time Prepared: 9/13/2014 2:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,512,696	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,661,708	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,850,988	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,518,456	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,667,468	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	55,638	6.00
7.00	Income from investments	142,561	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	686,995	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	EHR PAYMENTS	1,003,809	24.01
24.02	OTHER OP REV	609,837	24.02
24.03	CAPITAL CONTRIBUTIONS	334,958	24.03
25.00	Total other income (sum of lines 6-24)	2,833,798	25.00
26.00	Total (line 5 plus line 25)	1,166,330	26.00
27.00	LOSS ON DISPOSAL	48,071	27.00
27.01	CHARITY CARE	384,073	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	432,144	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	734,186	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H | Date/Time Prepared: 9/13/2014 2:33 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	98,217	0	3,662	13,209	3,210	118,298	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	349,140	0	56,648	0	0	405,788	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	36,926	0	0	0	0	36,926	11.00
12.00	Supplies (see instructions)	0	0	0	0	21,339	21,339	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)	484,283	0	60,310	13,209	24,549	582,351	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	118,298	-8,383	109,915			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	405,788	0	405,788			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	36,926	0	36,926			11.00
12.00	Supplies (see instructions)	0	21,339	0	21,339			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	582,351	-8,383	573,968			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-1 Part I Date/Time Prepared: 9/13/2014 2:33 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	109,915	0	0	0	0	109,915	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	405,788	0	0	0	0	405,788	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	36,926	0	0	0	0	36,926	11.00
12.00	Supplies (see instructions)	21,339	0	0	0	0	21,339	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)	573,968	0	0	0	0	573,968	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	109,915						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	96,115	501,903					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	8,746	45,672					11.00
12.00	Supplies (see instructions)	5,054	26,393					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)		573,968					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-1 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-109,915	464,053	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	405,788	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	36,926	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	21,339	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-109,915	464,053	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		109,915	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.236859	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 9/13/2014 2:33 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	27,807	258	142,928	13,335	1,294	1.00
2.00	Skilled Nursing Care	501,903	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	45,672	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	26,393	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)	573,968	27,807	258	142,928	13,335	1,294	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	7,256	192,878	16,474	18,377	0	1.00
2.00	Skilled Nursing Care	0	0	501,903	42,870	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	45,672	3,901	0	0	7.00
8.00	Supplies (see instructions)	0	0	26,393	2,254	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	7,256	766,846	65,499	18,377	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,509	0	0	41,203	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	3,509	0	0	41,203	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	18.00	24.00	25.00	26.00	
1.00	Administrative and General	0	4,955	0	277,396	0	277,396	1.00
2.00	Skilled Nursing Care	0	0	0	544,773	0	544,773	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	49,573	0	49,573	7.00
8.00	Supplies (see instructions)	0	0	0	28,647	0	28,647	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	4,955	0	900,389	0	900,389	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: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 9/13/2014 2:33 pm

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	242,568	787,341				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	0	0				6.00
7.00	Home Health Aide	22,073	71,646				7.00
8.00	Supplies (see instructions)	12,755	41,402				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	277,396	900,389				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.	0.445263					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2013 To 05/31/2014

Worksheet H-2 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	ADMITTING (GROSS CHAR GES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,008	247	484,283	2,150	22,406	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)	1,008	247	484,283	2,150	22,406	0	20.00
21.00	Total cost to be allocated	27,807	258	142,928	13,335	1,294	0	21.00
22.00	Unit cost multiplier	27.586310	1.044534	0.295133	6.202326	0.057752	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	957,084	0	192,878	1,008	0	3,100	1.00
2.00	Skilled Nursing Care	0	0	501,903	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	45,672	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	26,393	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)	957,084		766,846	1,008	0	3,100	20.00
21.00	Total cost to be allocated	7,256		65,499	18,377	0	3,509	21.00
22.00	Unit cost multiplier	0.007581		0.085413	18.231151	0.000000	1.131935	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2013 To 05/31/2014

Worksheet H-2 Part II Date/Time Prepared: 9/13/2014 2:33 pm

Home Health Agency I

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	897	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	897	0	0	0	20.00
21.00	Total cost to be allocated	0	0	41,203	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	45.934225	0.000000	0.000000	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)					
		17.00	18.00					
1.00	Administrative and General	1,905	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	1,905	0					20.00
21.00	Total cost to be allocated	4,955	0					21.00
22.00	Unit cost multiplier	2.601050	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 9/13/2014 2:33 pm

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

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	787,341		787,341	5,840	134.82	1.00
2.00	Physical Therapy	3.00	0	180,477	180,477	2,118	85.21	2.00
3.00	Occupational Therapy	4.00	0	91,058	91,058	1,070	85.10	3.00
4.00	Speech Pathology	5.00	0	16,460	16,460	160	102.88	4.00
5.00	Medical Social Services	6.00	0		0	29	0.00	5.00
6.00	Home Health Aide	7.00	71,646		71,646	1,897	37.77	6.00
7.00	Total (sum of lines 1-6)		858,987	287,995	1,146,982	11,114		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		19340	760	3,803			8.00
8.01	Skilled Nursing Care		37900	0	0			8.01
8.02	Skilled Nursing Care		99914	61	99			8.02
8.03	Skilled Nursing Care		50208	0	0			8.03
8.04	Skilled Nursing Care		49740	0	18			8.04
9.00	Physical Therapy		19340	397	1,134			9.00
9.01	Physical Therapy		37900	0	0			9.01
9.02	Physical Therapy		99914	47	54			9.02
9.03	Physical Therapy		50208	0	0			9.03
9.04	Physical Therapy		49740	0	12			9.04
10.00	Occupational Therapy		19340	134	724			10.00
10.01	Occupational Therapy		37900	0	0			10.01
10.02	Occupational Therapy		99914	14	28			10.02
10.03	Occupational Therapy		50208	0	0			10.03
10.04	Occupational Therapy		49740	0	0			10.04
11.00	Speech Pathology		19340	21	71			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		99914	0	0			11.02
11.03	Speech Pathology		50208	0	0			11.03
11.04	Speech Pathology		49740	0	0			11.04
12.00	Medical Social Services		19340	1	17			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		99914	1	0			12.02
12.03	Medical Social Services		50208	0	0			12.03
12.04	Medical Social Services		49740	0	0			12.04
13.00	Home Health Aide		19340	289	1,259			13.00
13.01	Home Health Aide		37900	0	0			13.01
13.02	Home Health Aide		99914	40	56			13.02
13.03	Home Health Aide		50208	0	0			13.03
13.04	Home Health Aide		49740	0	1			13.04
14.00	Total (sum of lines 8-13)			1,765	7,276			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	41,402	0	41,402	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 9/13/2014 2:33 pm

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

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	821	3,920		110,687	528,494		1.00
2.00	Physical Therapy	444	1,200		37,833	102,252		2.00
3.00	Occupational Therapy	148	752		12,595	63,995		3.00
4.00	Speech Pathology	21	71		2,160	7,304		4.00
5.00	Medical Social Services	2	17		0	0		5.00
6.00	Home Health Aide	329	1,316		12,426	49,705		6.00
7.00	Total (sum of lines 1-6)	1,765	7,276		175,701	751,750		7.00

	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 141319 HHA CCN: 147450	Period: From 06/01/2013 To 05/31/2014	Worksheet H-3 Part I Date/Time Prepared: 9/13/2014 2:33 pm
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	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	639,181		1.00
2.00	Physical Therapy	140,085		2.00
3.00	Occupational Therapy	76,590		3.00
4.00	Speech Pathology	9,464		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	62,131		6.00
7.00	Total (sum of lines 1-6)	927,451		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-3 Part II Date/Time Prepared: 9/13/2014 2:33 pm

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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	0.512327	352,269	180,477	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.510092	178,512	91,058	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.677677	24,289	16,460	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.207687	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.432358	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141319 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-4 Part I-II
HHA CCN: 147450 | Date/Time Prepared: 9/13/2014 2:33 pm

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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	302,635	566,832	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	302,635	566,832	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	302,635	566,832	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	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	184,563	840,078	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	17,524	27,019	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	3,905	12,594	13.00
14.00	Total PPS Reimbursement - PEP Episodes	868	5,089	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	3,053	8,611	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	33	468	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)	209,946	893,859	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	209,946	893,859	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	209,946	893,859	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	209,946	893,859	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	209,946	893,859	31.00
31.01	Sequestration adjustment (see instructions)	4,199	17,877	31.01
32.00	Interim payments (see instructions)	205,746	875,981	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	1	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2013 To 05/31/2014 | Worksheet H-5 Date/Time Prepared: 9/13/2014 2:33 pm

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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		205,746		875,981	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)		205,746		875,981	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		205,747		875,982	7.00

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