

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: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/22/2013 2:57 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/22/2013	Time: 2:57 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 SARAH BUSH LINCOLN HEALTH CENTER (140189) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-1,003,353	-942,700	1,352,712	0	1.00
2.00 Subprovider - IPF	0	99,941	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	-1	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		879		0	10.00
10.01 RURAL HEALTH CLINIC II	0		969		0	10.01
10.02 RURAL HEALTH CLINIC III	0		1,904		0	10.02
200.00 Total	0	-903,413	-938,948	1,352,712	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: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 2:52 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00			
1.00	Street: 1000 HEALTH CENTER DRIVE	PO Box: 372	Zip Code: 61920-		County: COLES				1.00
2.00	City: MATTOON	State: IL							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	SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF	SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	LINCOLN LAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	LINCOLN LAND HOSPICE OF SBLHS	141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC	CASEY RHC	143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC I I	SULLIVAN RHC	143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC I I I	NEOGA RHC	143435	99914		05/31/1997	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2012	06/30/2013	20.00	
21.00	Type of Control (see instructions)					2		21.00	

Inpatient PPS Information									
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N	22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	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 days	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.						3,409	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 2:52 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.	1			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.	07/01/2012	06/30/2013		36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N			39.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		
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				
62.01	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				
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				

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	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. 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)							64.00
		0.00		0.00	0.000000			
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							65.00
				0.00		0.00	0.000000	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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)							66.00
				0.00		0.00	0.000000	
		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		

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00	
					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.			Y		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00

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		V 1.00	XIX 2.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	6,533,793	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.	Y		Y		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N		140.00

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1.00		2.00		3.00										
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.														
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
Multi campus														
165.00	Is this hospital part of a Multi campus 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)						0.75		169.00					

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/22/2013 2:52 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
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	Type	Date
			1.00	2.00	3.00
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	Legal Oper.	
			1.00	2.00	
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
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	09/30/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/22/2013 2:52 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BARB		IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509		BI PPOLITO@SBLHS.ORG	43.00

		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)	09/30/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMB. ACCOUNTANT	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: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	80	29,200	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	32.00	9	3,285	0.00	0	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)		89	32,485	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		109				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	10,404	2,243	17,744			1.00
2.00 HMO	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	10,404	2,243	17,744			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	996	181	1,777			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		675	1,194			13.00
14.00 Total (see instructions)	11,400	3,099	20,715	0.00	1,381.68	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,053	1,036	3,423	0.00	22.71	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	31,463	0.00	52.10	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	23.97	24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	894	0	3,608	0.00	4.50	26.00
26.01 RURAL HEALTH CLINIC II	757	0	3,584	0.00	7.06	26.01
26.02 RURAL HEALTH CLINIC III	1,584	0	6,350	0.00	7.89	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,499.91	27.00
28.00 Observation Bed Days		0	4,070			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)		259	479			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	2,745	996	5,714	1.00
2.00 HMO			0			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,745	996	5,714	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	205	309	901	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet S-3 Part II Date/Time Prepared: 11/22/2013 2:52 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	98,365,325	0	98,365,325	3,120,025.00	31.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,864,669	0	1,864,669	19,982.00	93.32	3.00
4.00	Physician-Part A - Administrative		908,397	0	908,397	3,686.00	246.45	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		8,653,298	0	8,653,298	50,918.00	169.95	5.00
6.00	Non-physician-Part B		360,922	0	360,922	6,140.00	58.78	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		33,758,386	0	33,758,386	828,903.00	40.73	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		5,538	0	5,538	42.00	131.86	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		25,402,950	0	25,402,950			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		5,767,036	0	5,767,036			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		441,933	0	441,933			21.00
22.00	Physician Part A - Administrative		113,898	0	113,898			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,346,589	0	1,346,589			23.00
24.00	Wage-related costs (RHC/FOHC)		95,021	0	95,021			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	552,504	11,341	563,845	17,914.00	31.48	26.00
27.00	Administrative & General	5.00	11,283,030	0	11,283,030	391,159.00	28.85	27.00
28.00	Administrative & General under contract (see inst.)		458,264	0	458,264	1,451.25	315.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	989,278	0	989,278	46,661.00	21.20	30.00
31.00	Laundry & Linen Service	8.00	27,288	0	27,288	2,069.00	13.19	31.00
32.00	Housekeeping	9.00	1,257,333	0	1,257,333	94,792.00	13.26	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,325,097	-747,620	577,477	40,449.00	14.28	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	747,620	747,620	52,367.00	14.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,281,674	0	1,281,674	42,477.00	30.17	38.00
39.00	Central Services and Supply	14.00	408,800	0	408,800	27,633.00	14.79	39.00
40.00	Pharmacy	15.00	1,401,856	0	1,401,856	37,544.00	37.34	40.00
41.00	Medical Records & Medical Records Library	16.00	1,510,825	0	1,510,825	83,892.00	18.01	41.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140189			Period: From 07/01/2012 To 06/30/2013		Worksheet S-3 Part II Date/Time Prepared: 11/22/2013 2:52 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
42.00	Soci al Servi ce	17.00	0	0	0.00	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0.00	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

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

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2013 2:52 pm

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries (from Worksheet A-6)	Salaries (col . 2 ± col . 3)	Related to Salaries in col . 4	Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	87,944,700	0	87,944,700	3,044,436.25	28.89	1.00
2.00	Excluded area salaries (see instructions)	33,758,386	0	33,758,386	828,903.00	40.73	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,186,314	0	54,186,314	2,215,533.25	24.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,538	0	5,538	42.00	131.86	4.00
5.00	Subtotal wage-related costs (see inst.)	25,516,848	0	25,516,848	0.00	47.09	5.00
6.00	Total (sum of lines 3 thru 5)	79,708,700	0	79,708,700	2,215,575.25	35.98	6.00
7.00	Total overhead cost (see instructions)	20,495,949	11,341	20,507,290	838,408.25	24.46	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2013 2:52 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,612,874 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			490,848 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			13,014,340 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			674,522 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			251,715 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			23,072 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			177,427 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,392,264 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			5,559,728 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			101,657 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			104,503 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			25,402,950 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140189

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

Worksheet S-3
Part V
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet S-4	
		Component CCN: 147594				Date/Time Prepared: 11/22/2013 2:52 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	1,117.00	129.00	320.00	0.00	
				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)	0.00		0.64	0.00	0.64	
4.00	Director(s) and Assistant Director(s)			1.99	0.00	1.99	
5.00	Other Administrative Personnel			11.68	0.00	11.68	
6.00	Direct Nursing Service			25.25	0.00	25.25	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			5.73	0.00	5.73	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			1.84	0.00	1.84	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.66	0.00	0.66	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.96	0.00	0.96	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			3.35	0.00	3.35	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	12,071	1,305	304	334	14,014	
22.00	Skilled Nursing Visit Charges	2,144,089	222,002	58,458	60,754	2,485,303	
23.00	Physical Therapy Visits	4,167	46	51	160	4,424	
24.00	Physical Therapy Visit Charges	0	0	9,648	30,096	39,744	
25.00	Occupational Therapy Visits	1,381	24	16	65	1,486	
26.00	Occupational Therapy Visit Charges	253,473	4,368	2,973	12,134	272,948	
27.00	Speech Pathology Visits	294	0	6	0	300	
28.00	Speech Pathology Visit Charges	54,664	0	1,214	0	55,878	
29.00	Medical Social Service Visits	224	13	4	7	248	
30.00	Medical Social Service Visit Charges	49,952	2,899	892	1,561	55,304	
31.00	Home Health Aide Visits	3,074	235	7	51	3,367	
32.00	Home Health Aide Visit Charges	239,772	18,330	546	3,978	262,626	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	21,211	1,623	388	617	23,839	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,741,950	247,599	73,731	108,523	3,171,803	
36.00	Total Number of Episodes (standard/non outlier)	1,382		136	49	1,567	
37.00	Total Number of Outlier Episodes		36		4	40	
38.00	Total Non-Routine Medical Supply Charges	92,843	19,470	0	3,127	115,440	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm Cost
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		1.00			
1.00	Clinic Address and Identification	412 NW 3RD			1.00
	Street	City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	CASEY	IL	62420	2.00
		1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award	Date		
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)	0			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0			6.00
7.00	Appalachian Regional Commission	0			7.00
8.00	Look-Alikes	0			8.00
9.00	OTHER (SPECIFY)	0			9.00
		1.00			
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N			0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)	08:00			17:00
11.00	Clinic	08:00			17:00
		1.00			2.00
12.00	Have you received an approval for an exception to the productivity standard?	N			0 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				0 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number	Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
					Total Visits
					5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	0			0 15.00
		County			
		4.00			
2.00	City, State, Zip Code, County	CLARK			2.00
		Tuesday		Wednesday	Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
11.00	Facility hours of operations (1)	17:00			08:00
11.00	Clinic	17:00	08:00	17:00	08:00
		17:00			17:00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm Cost
			Rural Health Clinic (RHC) II	

				1.00		
1.00	Clinic Address and Identification			7 HAWTHORNE LANE		1.00
			City	State	Zip Code	
			1.00	2.00	3.00	
2.00	City, State, Zip Code, County		SULLIVAN IL		61951	2.00
				1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
				Grant Award	Date	
				1.00	2.00	
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00
			Sunday		Monday	Tuesday
			from	to	from	to
			1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)			08:00		17:00
			17:00		08:00	11.00
				1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?			N		0 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.					0 13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number			XVIII		XIX
			Total Visits			14.00
			1.00		2.00	3.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0		0
			0		0	0 15.00
			County			
			4.00			
2.00	City, State, Zip Code, County			MOULTRIE		2.00
			Tuesday		Wednesday	Thursday
			to	from	to	from
			6.00	7.00	8.00	9.00
11.00	Facility hours of operations (1)			17:00		08:00
			08:00		17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm	
			Rural Health Clinic (RHC) II	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm			
			Rural Health Clinic (RHC) III	Cost			
				1.00			
1.00	Clinic Address and Identification Street			650 OAK AVENUE	1.00		
			City	State	Zip Code		
			1.00	2.00	3.00		
2.00	City, State, Zip Code, County		NEOGA	IL	62447	2.00	
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00	
			Grant Award	Date			
			1.00	2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00		
7.00	Appalachian Regional Commission			0	7.00		
8.00	Look-Alikes			0	8.00		
9.00	OTHER (SPECIFY)			0	9.00		
				1.00	2.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1) Clinic			08:00	17:00	08:00	11.00
				1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?					12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00	
			Provider name		CCN number		
			1.00		2.00		
14.00	Provider name, CCN number					14.00	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0	0	0	15.00
			County				
			4.00				
2.00	City, State, Zip Code, County			CUMBERLAND		2.00	
		Tuesday		Wednesday		Thursday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11.00	Facility hours of operations (1) Clinic			17:00	08:00	17:00	11.00
		08:00		17:00		08:00	
		17:00		08:00		17:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/22/2013 2:52 pm	
			Rural Health Clinic (RHC) III	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 140189
Component CCN: 141599

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
11/22/2013 2:52 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	18,771	736	9,103	343	2,256	21,763	2.00
3.00	Inpatient Respite Care	241	0	0	0	0	241	3.00
4.00	General Inpatient Care	38	5	0	0	0	43	4.00
5.00	Total Hospice Days	19,050	741	9,103	343	2,256	22,047	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	524	22	302	10	67	613	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	36.35	33.68	30.14	34.30	33.67	35.97	8.00
9.00	Unduplicated Census Count	568	0	0	0	0	568	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/22/2013 2:52 pm
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				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)		0.279732		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,814,773		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		6,198,299		5.00
6.00	Medicaid charges		69,928,055		6.00
7.00	Medicaid cost (line 1 times line 6)		19,561,115		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)		6,548,043		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)		6,548,043		19.00
				1.00	
				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	4,558,377	20,180,862	24,739,239	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,275,124	5,645,233	6,920,357	21.00
22.00	Partial payment by patients approved for charity care	47,630	1,299,413	1,347,043	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,227,494	4,345,820	5,573,314	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)		10,559,942		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,102,801		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		9,457,141		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,645,465		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		8,218,779		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,766,822		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet A		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	NEW CAP REL COSTS-BLDG & FIXT		0	0	4,245,596	4,245,596	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	7,358,789	7,358,789	2.00
4.00	00400	EMPLOYEE BENEFITS	552,504	19,889,161	20,441,665	205,833	20,647,498	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,283,030	27,624,855	38,907,885	-13,111,187	25,796,698	5.00
7.00	00700	OPERATION OF PLANT	989,278	3,079,652	4,068,930	-39,747	4,029,183	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,288	467,137	494,425	0	494,425	8.00
9.00	00900	HOUSEKEEPING	1,257,333	375,869	1,633,202	-241	1,632,961	9.00
10.00	01000	DIETARY	1,325,097	1,164,571	2,489,668	-1,405,091	1,084,577	10.00
11.00	01100	CAFETERIA	0	0	0	1,404,671	1,404,671	11.00
13.00	01300	NURSING ADMINISTRATION	1,281,674	198,597	1,480,271	-3,553	1,476,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	408,800	736,895	1,145,695	0	1,145,695	14.00
15.00	01500	PHARMACY	1,401,856	7,804,180	9,206,036	-7,520,178	1,685,858	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510,825	493,419	2,004,244	-7,787	1,996,457	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,176,885	1,331,656	11,508,541	-881,158	10,627,383	30.00
32.00	03200	CORONARY CARE UNIT	1,142,487	180,923	1,323,410	-280	1,323,130	32.00
40.00	04000	SUBPROVIDER - IPF	2,284,603	238,811	2,523,414	20,872	2,544,286	40.00
43.00	04300	NURSERY	0	8,769	8,769	365,756	374,525	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,369,451	1,682,484	6,051,935	-35,190	6,016,745	50.00
51.00	05100	RECOVERY ROOM	688,400	130,650	819,050	-4,827	814,223	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,979	68,979	555,290	624,269	52.00
53.00	05300	ANESTHESIOLOGY	5,326,776	574,328	5,901,104	475,275	6,376,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,878,797	863,105	2,741,902	-285,959	2,455,943	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,779,961	396,476	2,176,437	31,727	2,208,164	55.00
56.00	05600	RADIOISOTOPE	947,594	1,086,828	2,034,422	172,055	2,206,477	56.00
57.00	05700	CT SCAN	311,337	654,130	965,467	59,272	1,024,739	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,102	158,373	397,475	41,097	438,572	58.00
59.00	05900	CARDIAC CATHETERIZATION	381,348	234,349	615,697	-1,230	614,467	59.00
60.00	06000	LABORATORY	4,244,153	4,967,433	9,211,586	10,538	9,222,124	60.00
65.00	06500	RESPIRATORY THERAPY	833,491	239,564	1,073,055	-16,868	1,056,187	65.00
66.00	06600	PHYSICAL THERAPY	1,594,624	642,810	2,237,434	-18,837	2,218,597	66.00
67.00	06700	OCCUPATIONAL THERAPY	365,674	44,239	409,913	0	409,913	67.00
68.00	06800	SPEECH PATHOLOGY	692,485	430,097	1,122,582	-949	1,121,633	68.00
69.00	06900	ELECTROCARDIOLOGY	1,073,238	1,618,852	2,692,090	6,672	2,698,762	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	353,416	689,519	1,042,935	3,860	1,046,795	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,496,835	3,496,835	0	3,496,835	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,571,186	4,571,186	0	4,571,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,369,782	7,369,782	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	442,543	51,683	494,226	-12,375	481,851	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	265,855	86,142	351,997	9,346	361,343	88.00
88.01	08801	RURAL HEALTH CLINIC II	491,245	128,548	619,793	22,827	642,620	88.01
88.02	08802	RURAL HEALTH CLINIC III	689,360	102,088	791,448	22,670	814,118	88.02
91.00	09100	EMERGENCY	6,281,032	2,295,165	8,576,197	319,898	8,896,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,928,806	689,767	3,618,573	-14,044	3,604,529	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,197,406	894,650	2,092,056	-199,819	1,892,237	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,017,754	90,392,775	161,410,529	-857,494	160,553,035	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,337,781	5,942,666	31,280,447	1,064,408	32,344,855	192.00
194.00	07950	WELLNESS	225,812	227,967	453,779	-2,159	451,620	194.00
194.02	07951	LIFELINE	37,770	125,475	163,245	0	163,245	194.02
194.03	07952	OCCUPATIONAL HEALTH	418,448	108,244	526,692	-200,594	326,098	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,327,760	628,373	1,956,133	-4,161	1,951,972	194.05
200.00		TOTAL (SUM OF LINES 118-199)	98,365,325	97,425,500	195,790,825	0	195,790,825	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140189

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

Worksheet A
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,099,548	3,146,048	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	7,358,789	2.00
4.00	00400	EMPLOYEE BENEFITS	-344,876	20,302,622	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,799,304	22,997,394	5.00
7.00	00700	OPERATION OF PLANT	-66	4,029,117	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	494,425	8.00
9.00	00900	HOUSEKEEPING	-1,195	1,631,766	9.00
10.00	01000	DIETARY	-10,322	1,074,255	10.00
11.00	01100	CAFETERIA	-720,870	683,801	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,476,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,145,695	14.00
15.00	01500	PHARMACY	0	1,685,858	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-94,633	1,901,824	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,776,440	8,850,943	30.00
32.00	03200	CORONARY CARE UNIT	0	1,323,130	32.00
40.00	04000	SUBPROVIDER - IPF	-1,203,312	1,340,974	40.00
43.00	04300	NURSERY	0	374,525	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,016,745	50.00
51.00	05100	RECOVERY ROOM	0	814,223	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	624,269	52.00
53.00	05300	ANESTHESIOLOGY	-5,645,148	731,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,446	2,454,497	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,076,090	1,132,074	55.00
56.00	05600	RADIOISOTOPE	-1,000	2,205,477	56.00
57.00	05700	CT SCAN	-2,875	1,021,864	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	438,572	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	614,467	59.00
60.00	06000	LABORATORY	-659,550	8,562,574	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,056,187	65.00
66.00	06600	PHYSICAL THERAPY	-7,506	2,211,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	409,913	67.00
68.00	06800	SPEECH PATHOLOGY	-721,337	400,296	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,600,201	1,098,561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-454,219	592,576	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,496,835	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,571,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,369,782	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	481,851	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	361,343	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	642,620	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	814,118	88.02
91.00	09100	EMERGENCY	-3,176,455	5,719,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	3,604,529	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	1,892,237	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-21,396,393	139,156,642	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,344,855	192.00
194.00	07950	WELLNESS	0	451,620	194.00
194.02	07951	LIFELINE	0	163,245	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	326,098	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	1,951,972	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-21,396,393	174,394,432	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,369,782	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			0	7,369,782	
B - RADIOLOGY ADMIN EXPENSES					
1.00	RADIOISOTOPE	56.00	150,328	21,727	1.00
2.00	CT SCAN	57.00	49,391	13,077	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	37,931	3,166	3.00
TOTALS			237,650	37,970	
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	672,231	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
TOTALS			0	672,231	
D - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,172,961	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	6,686,558	2.00
TOTALS			0	9,859,519	
E - CAFETERIA					
1.00	CAFETERIA	11.00	747,620	657,051	1.00
TOTALS			747,620	657,051	
F - EMPLOYEE PHYSICALS					
1.00	EMPLOYEE BENEFITS	4.00	0	199,508	1.00
TOTALS			0	199,508	
G - EAP BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	11,341	1,034	1.00
TOTALS			11,341	1,034	
H - PHYSN PROF LIABILITY EXP					
1.00	ADULTS & PEDIATRICS	30.00	0	56,897	1.00
2.00	SUBPROVIDER - IPF	40.00	0	21,897	2.00
3.00	ANESTHESIOLOGY	53.00	0	478,026	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	33,875	4.00
5.00	LABORATORY	60.00	0	18,529	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	10,007	6.00
7.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,531	7.00
8.00	EMERGENCY	91.00	0	329,248	8.00

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
11/22/2013 2:52 pm

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
9.00	RURAL HEALTH CLINIC	88.00	0	10,007		9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	23,379		10.00
11.00	RURAL HEALTH CLINIC III	88.02	0	23,379		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,100,227		12.00
	TOTALS		0	2,115,002		
I - DEFAULT						
1.00	NURSERY	43.00	365,910	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	555,290	0		2.00
	TOTALS		921,200	0		
J - INTEREST EXP						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,099,548		1.00
	TOTALS		0	1,099,548		
500.00	Grand Total: Increases		1,917,811	22,011,645		500.00

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6
Date/Time Prepared:
11/22/2013 2:52 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	7,357,232	0		1.00
2.00	OPERATING ROOM	50.00	0	3,106	0		2.00
3.00	RECOVERY ROOM	51.00	0	3,497	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	2,751	0		4.00
5.00	CT_SCAN	57.00	0	3,196	0		5.00
TOTALS			0	7,369,782			
B - RADIOLOGY ADMIN EXPENSES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	237,650	37,970	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
TOTALS			237,650	37,970			
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS							
1.00	EMPLOYEE BENEFITS	4.00	0	6,050	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	37,118	14		2.00
3.00	OPERATION OF PLANT	7.00	0	39,747	14		3.00
4.00	HOUSEKEEPING	9.00	0	241	14		4.00
5.00	DIETARY	10.00	0	420	14		5.00
6.00	NURSING ADMINISTRATION	13.00	0	3,553	14		6.00
7.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26,913	14		7.00
8.00	PHARMACY	15.00	0	162,946	14		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,787	14		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	16,855	14		10.00
11.00	CORONARY CARE UNIT	32.00	0	280	14		11.00
12.00	SUBPROVIDER - IPF	40.00	0	1,025	14		12.00
13.00	NURSERY	43.00	0	154	14		13.00
14.00	OPERATING ROOM	50.00	0	32,084	14		14.00
15.00	RECOVERY ROOM	51.00	0	1,330	14		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,339	14		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,148	14		17.00
18.00	LABORATORY	60.00	0	7,991	14		18.00
19.00	RESPIRATORY THERAPY	65.00	0	16,868	14		19.00
20.00	PHYSICAL THERAPY	66.00	0	18,837	14		20.00
21.00	SPEECH PATHOLOGY	68.00	0	949	14		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	3,335	14		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,671	14		23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	1,230	14		24.00
25.00	EMERGENCY	91.00	0	9,350	14		25.00
26.00	RURAL HEALTH CLINIC	88.00	0	661	14		26.00
27.00	RURAL HEALTH CLINIC II	88.01	0	552	14		27.00
28.00	RURAL HEALTH CLINIC III	88.02	0	709	14		28.00
29.00	HOME HEALTH AGENCY	101.00	0	14,044	14		29.00
30.00	HOSPICE	116.00	0	199,819	14		30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35,819	14		31.00
32.00	WELLNESS	194.00	0	2,159	14		32.00
33.00	OCCUPATIONAL HEALTH	194.03	0	1,086	14		33.00
34.00	MISC. NONREIMBURSABLE	194.05	0	4,161	0		34.00
TOTALS			0	672,231			
D - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,859,519	9		1.00
2.00		0.00	0	0	9		2.00
TOTALS			0	9,859,519			
E - CAFETERIA							
1.00	DIETARY	10.00	747,620	657,051	0		1.00
TOTALS			747,620	657,051			
F - EMPLOYEE PHYSICALS							
1.00	OCCUPATIONAL HEALTH	194.03	0	199,508	0		1.00
TOTALS			0	199,508			
G - EAP BENEFITS							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	11,341	1,034	0		1.00
TOTALS			11,341	1,034			
H - PHYSN PROF LIABILITY EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,115,002	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
11/22/2013 2:52 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		0	2,115,002			
I - DEFAULT							
1.00	ADULTS & PEDIATRICS	30.00	921,200	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		921,200	0			
J - INTEREST EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,099,548	11		1.00
	TOTALS		0	1,099,548			
500.00	Grand Total: Decreases		1,917,811	22,011,645			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,194,269	0	0	0	0	1.00
2.00	Land Improvements	7,097,949	110,208	0	110,208	0	2.00
3.00	Buildings and Fixtures	78,745,207	7,605,149	0	7,605,149	2,647,404	3.00
4.00	Building Improvements	169,556	310,281	0	310,281	0	4.00
5.00	Fixed Equipment	13,601,378	220,480	0	220,480	579,361	5.00
6.00	Movable Equipment	71,159,682	6,581,107	0	6,581,107	3,500,387	6.00
7.00	HIT designated Assets	442,205	6,335	0	6,335	0	7.00
8.00	Subtotal (sum of lines 1-7)	174,410,246	14,833,560	0	14,833,560	6,727,152	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	174,410,246	14,833,560	0	14,833,560	6,727,152	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,194,269	0				1.00
2.00	Land Improvements	7,208,157	0				2.00
3.00	Buildings and Fixtures	83,702,952	0				3.00
4.00	Building Improvements	479,837	0				4.00
5.00	Fixed Equipment	13,242,497	0				5.00
6.00	Movable Equipment	74,240,402	0				6.00
7.00	HIT designated Assets	448,540	0				7.00
8.00	Subtotal (sum of lines 1-7)	182,516,654	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	182,516,654	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2013 2:52 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,172,960	0	3,172,960	0.321817	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,686,559	0	6,686,559	0.678183	0	2.00
3.00	Total (sum of lines 1-2)	9,859,519	0	9,859,519	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,172,961	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	6,686,558	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,859,519	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	-26,913	3,146,048	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	672,231	7,358,789	2.00
3.00	Total (sum of lines 1-2)	0	0	0	645,318	10,504,837	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

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

Worksheet A-8

Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW 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	-13,390,414			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-720,870	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-94,633	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-1,195	HOUSEKEEPING	9.00	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	ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 INVESTMENT INCOME	B	-1,099,548	ONEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00

Provider CCN: 140189
 Period: From 07/01/2012 To 06/30/2013
 Worksheet A-8
 Date/Time Prepared: 11/22/2013 2:52 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 A&G OTHER INCOME	B	-144,232	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 DIETARY OUTREACH REVENUE	B	-10,322	DIETARY	10.00	0	36.00
37.00 FACILITIES SVC OTHER REV	B	-66	OPERATION OF PLANT	7.00	0	37.00
38.00 W&C OTHER REV (BABY CLASSES)	B	-5,369	ADULTS & PEDIATRICS	30.00	0	38.00
39.00 XRAY OTHER REVENUE	B	-1,446	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
41.00 PHYSICAL THERAPY OTHER REV	B	-7,506	PHYSICAL THERAPY	66.00	0	41.00
42.00 MEDICAID ASSESSMENT TAX	A	-2,617,066	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00 SPEECH/AUDIO OTHER REV	B	-721,337	SPEECH PATHOLOGY	68.00	0	43.00
44.00 CARDIOLOGY OTHER REV	B	-80,579	ELECTROCARDIOLOGY	69.00	0	44.00
45.00 EMERGENCY (EMS) OTHER REV	B	-151,664	EMERGENCY	91.00	0	45.00
45.01 AHA/IHA LOBBYING FEES	A	-38,006	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02 CRNA S&W (EMPLOYEES & LOCUM TENENS)	A	-1,967,264	ANESTHESIOLOGY	53.00	0	45.02
45.03 CRNA (BENEFIT EXP)	A	-344,876	EMPLOYEE BENEFITS	4.00	0	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,396,393				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

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

Worksheet A-8-2

Date/Time Prepared:
11/22/2013 2:52 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	30.00	ADULTS & PEDIATRICS	1,375,605	1,375,605	0	138,700	0	1.00
2.00	30.00	DR. A	442,162	297,150	145,012	138,700	605	2.00
3.00	40.00	DR. B	1,203,312	1,203,312	0	138,700	0	3.00
4.00	53.00	ANESTHESIOLOGY	3,291,798	3,291,798	0	167,500	0	4.00
5.00	53.00	DR. C	534,043	140,939	393,104	167,500	1,495	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	1,076,090	1,076,090	0	217,600	0	6.00
7.00	57.00	CT SCAN	2,875	2,875	0	217,600	0	7.00
8.00	56.00	RADIOISOTOPE	1,000	1,000	0	217,600	0	8.00
9.00	60.00	DR. D	343,320	297,180	46,140	208,000	267	9.00
10.00	60.00	DR. E	355,385	339,110	16,275	208,000	104	10.00
11.00	69.00	ELECTROCARDIOLOGY	1,519,622	1,519,622	0	159,800	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	454,219	454,219	0	159,800	0	12.00
13.00	91.00	EMERGENCY	2,225,846	2,225,846	0	159,800	0	13.00
14.00	91.00	DR. F	556,213	278,106	278,107	159,800	1,040	14.00
15.00	91.00	DR. G	351,711	321,951	29,760	159,800	176	15.00
200.00			13,733,201	12,824,803	908,398		3,687	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	21,936	0	43,525	1.00
2.00	30.00	DR. A	40,343	2,017	6,000	1,968	13,372	2.00
3.00	40.00	DR. B	0	0	15,653	0	21,897	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	59,329	0	446,577	4.00
5.00	53.00	DR. C	120,391	6,020	6,000	4,417	31,449	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	1,500	0	33,875	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	56.00	RADIOISOTOPE	0	0	0	0	0	8.00
9.00	60.00	DR. D	26,700	1,335	2,293	308	9,265	9.00
10.00	60.00	DR. E	10,400	520	1,701	78	9,264	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	3,222	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	43,905	0	302,133	13.00
14.00	91.00	DR. F	79,900	3,995	4,000	2,000	27,115	14.00
15.00	91.00	DR. G	13,521	676	0	0	0	15.00
200.00			291,255	14,563	165,539	8,771	938,472	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,375,605		1.00
2.00	30.00	DR. A	4,385	46,696	98,316	395,466		2.00
3.00	40.00	DR. B	0	0	0	1,203,312		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	3,291,798		4.00
5.00	53.00	DR. C	23,149	147,957	245,147	386,086		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	1,076,090		6.00
7.00	57.00	CT SCAN	0	0	0	2,875		7.00
8.00	56.00	RADIOISOTOPE	0	0	0	1,000		8.00
9.00	60.00	DR. D	1,245	28,253	17,887	315,067		9.00
10.00	60.00	DR. E	424	10,902	5,373	344,483		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,519,622		11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	454,219		12.00
13.00	91.00	EMERGENCY	0	0	0	2,225,846		13.00
14.00	91.00	DR. F	13,558	95,458	182,649	460,755		14.00
15.00	91.00	DR. G	0	13,521	16,239	338,190		15.00
200.00			42,761	342,787	565,611	13,390,414		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	3,146,048	3,146,048				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	7,358,789		7,358,789			2.00
4.00 00400 EMPLOYEE BENEFITS	20,302,622	25,799	9,099	20,337,520		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	22,997,394	451,853	1,669,647	2,346,272	27,465,166	5.00
7.00 00700 OPERATION OF PLANT	4,029,117	223,783	103,172	205,717	4,561,789	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	494,425	7,490	0	5,674	507,589	8.00
9.00 00900 HOUSEKEEPING	1,631,766	65,442	7,102	261,459	1,965,769	9.00
10.00 01000 DIETARY	1,074,255	46,294	41,601	120,085	1,282,235	10.00
11.00 01100 CAFETERIA	683,801	28,020	53,858	155,465	921,144	11.00
13.00 01300 NURSING ADMINISTRATION	1,476,718	9,994	3,438	266,520	1,756,670	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1,145,695	44,989	180,550	85,009	1,456,243	14.00
15.00 01500 PHARMACY	1,685,858	20,700	19,011	291,512	2,017,081	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,901,824	22,456	7,427	314,172	2,245,879	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	8,850,943	236,203	239,729	1,924,692	11,251,567	30.00
32.00 03200 CORONARY CARE UNIT	1,323,130	31,258	39,096	237,577	1,631,061	32.00
40.00 04000 SUBPROVIDER - I/PF	1,340,974	61,479	22,084	475,076	1,899,613	40.00
43.00 04300 NURSERY	374,525	4,352	14,703	76,090	469,670	43.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6,016,745	246,718	1,052,560	908,614	8,224,637	50.00
51.00 05100 RECOVERY ROOM	814,223	11,094	12,291	143,151	980,759	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	624,269	9,923	77,489	115,471	827,152	52.00
53.00 05300 ANESTHESIOLOGY	731,231	4,556	87,704	1,107,687	1,931,178	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,454,497	95,466	911,346	341,272	3,802,581	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,132,074	48,255	317,139	370,138	1,867,606	55.00
56.00 05600 RADIOISOTOPE	2,205,477	13,739	239,729	228,310	2,687,255	56.00
57.00 05700 CT SCAN	1,021,864	10,762	349,172	75,012	1,456,810	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	438,572	14,409	396,108	57,608	906,697	58.00
59.00 05900 CARDIAC CATHETERIZATION	614,467	20,044	231,350	79,300	945,161	59.00
60.00 06000 LABORATORY	8,562,574	62,543	426,215	882,559	9,933,891	60.00
65.00 06500 RESPIRATORY THERAPY	1,056,187	10,896	53,624	173,322	1,294,029	65.00
66.00 06600 PHYSICAL THERAPY	2,211,091	101,404	44,818	331,597	2,688,910	66.00
67.00 06700 OCCUPATIONAL THERAPY	409,913	2,976	7,095	76,041	496,025	67.00
68.00 06800 SPEECH PATHOLOGY	400,296	21,821	20,257	144,000	586,374	68.00
69.00 06900 ELECTROCARDIOLOGY	1,098,561	40,433	127,473	223,177	1,489,644	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	592,576	32,379	46,625	73,492	745,072	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,496,835	0	0	0	3,496,835	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,571,186	0	0	0	4,571,186	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7,369,782	0	0	0	7,369,782	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	481,851	19,176	5,328	89,667	596,022	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	361,343	100,459	9,797	55,284	526,883	88.00
88.01 08801 RURAL HEALTH CLINIC II	642,620	48,953	2,544	102,153	796,270	88.01
88.02 08802 RURAL HEALTH CLINIC III	814,118	19,966	4,347	143,350	981,781	88.02
91.00 09100 EMERGENCY	5,719,640	63,362	100,683	1,306,122	7,189,807	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	3,604,529	28,140	3,836	609,036	4,245,541	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	1,892,237	10,579	0	248,997	2,151,813	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	139,156,642	2,318,165	6,938,047	14,650,680	132,221,177	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	32,344,855	675,975	207,576	5,268,910	38,497,316	192.00
194.00 07950 WELLNESS	451,620	0	2,278	46,957	500,855	194.00
194.02 07951 LIFELINE	163,245	1,693	0	7,854	172,792	194.02
194.03 07952 OCCUPATIONAL HEALTH	326,098	20,530	5,282	87,015	438,925	194.03
194.05 07954 MISCELLANEOUS NONREIMBURSABLE	1,951,972	129,685	205,606	276,104	2,563,367	194.05
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0		0
202.00	TOTAL (sum lines 118-201)	174,394,432	3,146,048	7,358,789	20,337,520	174,394,432

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,465,166				5.00
7.00	00700	OPERATION OF PLANT	852,726	5,414,515			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,883	17,440	619,912		8.00
9.00	00900	HOUSEKEEPING	367,457	104,955	0	2,438,181	9.00
10.00	01000	DIETARY	239,686	107,796	0	0	1,629,717
11.00	01100	CAFETERIA	172,188	65,246	7,307	115,377	0
13.00	01300	NURSING ADMINISTRATION	328,371	23,270	0	12,820	0
14.00	01400	CENTRAL SERVICES & SUPPLY	272,213	104,758	13,282	33,270	0
15.00	01500	PHARMACY	377,049	43,273	0	12,820	0
16.00	01600	MEDICAL RECORDS & LIBRARY	419,818	65,870	0	12,209	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,103,233	549,998	213,660	39,070	1,276,634
32.00	03200	CORONARY CARE UNIT	304,891	72,783	17,833	83,938	66,002
40.00	04000	SUBPROVIDER - IPF	355,091	143,153	10,253	110,188	227,073
43.00	04300	NURSERY	87,794	10,133	5,534	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,537,415	574,483	124,318	536,901	24,858
51.00	05100	RECOVERY ROOM	183,331	25,832	16,469	18,619	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	154,618	23,106	14,433	0	0
53.00	05300	ANESTHESIOLOGY	360,991	10,609	0	1,221	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	710,809	222,292	62,379	62,877	0
55.00	05500	RADIOLOGY-THERAPEUTIC	349,108	112,361	8,821	68,982	0
56.00	05600	RADIOISOTOPE	502,323	31,991	0	25,334	0
57.00	05700	CT SCAN	272,319	25,060	0	14,651	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	169,487	33,551	0	6,410	0
59.00	05900	CARDIAC CATHETERIZATION	176,677	46,672	5,121	54,331	0
60.00	06000	LABORATORY	1,856,922	145,633	155	100,421	0
65.00	06500	RESPIRATORY THERAPY	241,890	25,372	0	9,767	0
66.00	06600	PHYSICAL THERAPY	502,633	126,895	11,264	105,305	0
67.00	06700	OCCUPATIONAL THERAPY	92,721	0	0	1,526	0
68.00	06800	SPEECH PATHOLOGY	109,610	41,417	163	10,683	0
69.00	06900	ELECTROCARDIOLOGY	278,456	94,149	5,669	61,046	0
70.00	07000	ELECTROENCEPHALOGRAPHY	139,275	75,395	1,405	42,122	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	653,656	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	854,483	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,377,619	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	111,413	44,652	0	25,029	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	98,489	233,919	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	148,845	113,987	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	183,522	46,491	0	0	0
91.00	09100	EMERGENCY	1,343,976	147,538	101,164	321,408	35,150
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	793,610	53,799	0	11,904	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	402,234	38,428	0	21,366	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,581,832	3,602,307	619,230	1,919,595	1,629,717
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,196,198	1,458,490	611	428,238	0
194.00	07950	WELLNESS	93,624	0	51	9,462	0
194.02	07951	LIFELINE	32,300	3,941	0	0	0
194.03	07952	OCCUPATIONAL HEALTH	82,047	47,805	20	25,639	0
194.05	07954	MISC. NONREIMBURSABLE	479,165	301,972	0	55,247	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	27,465,166	5,414,515	619,912	2,438,181	1,629,717

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet B Part I Date/Time Prepared: 11/22/2013 2:52 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,281,262					11.00
13.00	01300	26,721	2,147,852				13.00
14.00	01400	17,369	0	1,897,135			14.00
15.00	01500	24,049	0	0	2,474,272		15.00
16.00	01600	53,442	0	0	0	2,797,218	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	236,481	951,440	0	0	154,678	30.00
32.00	03200	26,721	109,994	0	0	18,699	32.00
40.00	04000	30,729	106,651	0	0	23,191	40.00
43.00	04300	9,352	38,418	0	0	8,978	43.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	112,227	464,138	0	0	317,262	50.00
51.00	05100	16,032	65,199	0	0	31,536	51.00
52.00	05200	13,360	55,636	0	0	27,608	52.00
53.00	05300	28,057	22,027	0	0	60,038	53.00
54.00	05400	34,737	0	0	0	148,801	54.00
55.00	05500	21,377	0	0	0	66,619	55.00
56.00	05600	17,369	0	0	0	125,749	56.00
57.00	05700	8,016	0	0	0	237,898	57.00
58.00	05800	5,344	0	0	0	101,085	58.00
59.00	05900	8,016	0	0	0	25,987	59.00
60.00	06000	113,563	0	0	0	306,226	60.00
65.00	06500	22,713	0	0	0	49,152	65.00
66.00	06600	32,065	0	0	0	61,124	66.00
67.00	06700	6,680	0	0	0	9,994	67.00
68.00	06800	14,696	0	0	0	12,080	68.00
69.00	06900	26,721	0	0	0	34,525	69.00
70.00	07000	2,672	0	0	0	34,527	70.00
71.00	07100	0	0	853,711	0	139,010	71.00
72.00	07200	0	0	1,043,424	0	113,611	72.00
73.00	07300	0	0	0	2,474,272	352,334	73.00
75.00	07500	0	0	0	0	0	75.00
76.00	03020	14,696	0	0	0	1,424	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	2,652	88.00
88.01	08801	0	0	0	0	3,619	88.01
88.02	08802	0	0	0	0	6,261	88.02
91.00	09100	94,859	334,349	0	0	250,072	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	14,696	0	0	0	35,228	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	5,344	0	0	0	37,250	116.00
118.00		1,038,104	2,147,852	1,897,135	2,474,272	2,797,218	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	207,086	0	0	0	0	192.00
194.00	07950	8,016	0	0	0	0	194.00
194.02	07951	1,336	0	0	0	0	194.02
194.03	07952	10,688	0	0	0	0	194.03
194.05	07954	16,032	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,281,262	2,147,852	1,897,135	2,474,272	2,797,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,776,761	0	16,776,761	30.00
32.00	03200	CORONARY CARE UNIT	2,331,922	0	2,331,922	32.00
40.00	04000	SUBPROVIDER - IPF	2,905,942	0	2,905,942	40.00
43.00	04300	NURSERY	629,879	0	629,879	43.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,916,239	0	11,916,239	50.00
51.00	05100	RECOVERY ROOM	1,337,777	0	1,337,777	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,115,913	0	1,115,913	52.00
53.00	05300	ANESTHESIOLOGY	2,414,121	0	2,414,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,044,476	0	5,044,476	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,494,874	0	2,494,874	55.00
56.00	05600	RADIOISOTOPE	3,390,021	0	3,390,021	56.00
57.00	05700	CT SCAN	2,014,754	0	2,014,754	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,222,574	0	1,222,574	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,261,965	0	1,261,965	59.00
60.00	06000	LABORATORY	12,456,811	0	12,456,811	60.00
65.00	06500	RESPIRATORY THERAPY	1,642,923	0	1,642,923	65.00
66.00	06600	PHYSICAL THERAPY	3,528,196	0	3,528,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	606,946	0	606,946	67.00
68.00	06800	SPEECH PATHOLOGY	775,023	0	775,023	68.00
69.00	06900	ELECTROCARDIOLOGY	1,990,210	0	1,990,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040,468	0	1,040,468	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,143,212	0	5,143,212	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,582,704	0	6,582,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,574,007	0	11,574,007	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	793,236	0	793,236	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	861,943	0	861,943	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,062,721	0	1,062,721	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,218,055	0	1,218,055	88.02
91.00	09100	EMERGENCY	9,818,323	0	9,818,323	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,154,778	0	5,154,778	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,656,435	0	2,656,435	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,763,209	0	121,763,209	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,787,939	0	47,787,939	192.00
194.00	07950	WELLNESS	612,008	0	612,008	194.00
194.02	07951	LIFELINE	210,369	0	210,369	194.02
194.03	07952	OCCUPATIONAL HEALTH	605,124	0	605,124	194.03
194.05	07954	MISC. NONREIMBURSABLE	3,415,783	0	3,415,783	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	174,394,432	0	174,394,432	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140189

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

Worksheet B
Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	25,799	9,099	34,898	34,898 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	451,853	1,669,647	2,121,500	4,028 5.00
7.00 00700	OPERATION OF PLANT	0	223,783	103,172	326,955	353 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,490	0	7,490	10 8.00
9.00 00900	HOUSEKEEPING	0	65,442	7,102	72,544	449 9.00
10.00 01000	DIETARY	0	46,294	41,601	87,895	206 10.00
11.00 01100	CAFETERIA	0	28,020	53,858	81,878	267 11.00
13.00 01300	NURSING ADMINISTRATION	0	9,994	3,438	13,432	458 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	44,989	180,550	225,539	146 14.00
15.00 01500	PHARMACY	0	20,700	19,011	39,711	500 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	22,456	7,427	29,883	539 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	236,203	239,729	475,932	3,304 30.00
32.00 03200	CORONARY CARE UNIT	0	31,258	39,096	70,354	408 32.00
40.00 04000	SUBPROVIDER - I PF	0	61,479	22,084	83,563	816 40.00
43.00 04300	NURSERY	0	4,352	14,703	19,055	131 43.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	246,718	1,052,560	1,299,278	1,560 50.00
51.00 05100	RECOVERY ROOM	0	11,094	12,291	23,385	246 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	9,923	77,489	87,412	198 52.00
53.00 05300	ANESTHESIOLOGY	0	4,556	87,704	92,260	1,902 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	95,466	911,346	1,006,812	586 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	48,255	317,139	365,394	635 55.00
56.00 05600	RADIOISOTOPE	0	13,739	239,729	253,468	392 56.00
57.00 05700	CT SCAN	0	10,762	349,172	359,934	129 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,409	396,108	410,517	99 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	20,044	231,350	251,394	136 59.00
60.00 06000	LABORATORY	0	62,543	426,215	488,758	1,515 60.00
65.00 06500	RESPIRATORY THERAPY	0	10,896	53,624	64,520	298 65.00
66.00 06600	PHYSICAL THERAPY	0	101,404	44,818	146,222	569 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,976	7,095	10,071	131 67.00
68.00 06800	SPEECH PATHOLOGY	0	21,821	20,257	42,078	247 68.00
69.00 06900	ELECTROCARDIOLOGY	0	40,433	127,473	167,906	383 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	32,379	46,625	79,004	126 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00 03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	19,176	5,328	24,504	154 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	100,459	9,797	110,256	95 88.00
88.01 08801	RURAL HEALTH CLINIC II	0	48,953	2,544	51,497	175 88.01
88.02 08802	RURAL HEALTH CLINIC III	0	19,966	4,347	24,313	246 88.02
91.00 09100	EMERGENCY	0	63,362	100,683	164,045	2,242 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	28,140	3,836	31,976	1,046 101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	10,579	0	10,579	427 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,318,165	6,938,047	9,256,212	25,152 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	675,975	207,576	883,551	9,029 192.00
194.00 07950	WELLNESS	0	0	2,278	2,278	81 194.00
194.02 07951	LIFELINE	0	1,693	0	1,693	13 194.02
194.03 07952	OCCUPATIONAL HEALTH	0	20,530	5,282	25,812	149 194.03
194.05 07954	MISC. NONREIMBURSABLE	0	129,685	205,606	335,291	474 194.05
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	3,146,048	7,358,789	10,504,837	34,898 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140189

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

Worksheet B
Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,125,528				5.00
7.00	00700	OPERATION OF PLANT	65,991	393,299			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,343	1,267	16,110		8.00
9.00	00900	HOUSEKEEPING	28,437	7,624	0	109,054	9.00
10.00	01000	DIETARY	18,549	7,830	0	0	114,480
11.00	01100	CAFETERIA	13,325	4,739	190	5,161	0
13.00	01300	NURSING ADMINISTRATION	25,412	1,690	0	573	0
14.00	01400	CENTRAL SERVICES & SUPPLY	21,066	7,609	345	1,488	0
15.00	01500	PHARMACY	29,179	3,143	0	573	0
16.00	01600	MEDICAL RECORDS & LIBRARY	32,489	4,785	0	546	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	162,765	39,951	5,553	1,747	89,678
32.00	03200	CORONARY CARE UNIT	23,595	5,287	463	3,754	4,636
40.00	04000	SUBPROVIDER - IPF	27,480	10,398	266	4,928	15,951
43.00	04300	NURSERY	6,794	736	144	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	118,978	41,729	3,231	24,017	1,746
51.00	05100	RECOVERY ROOM	14,188	1,876	428	833	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,966	1,678	375	0	0
53.00	05300	ANESTHESIOLOGY	27,936	771	0	55	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,008	16,147	1,621	2,812	0
55.00	05500	RADIOLOGY-THERAPEUTIC	27,017	8,162	229	3,085	0
56.00	05600	RADIOISOTOPE	38,874	2,324	0	1,133	0
57.00	05700	CT SCAN	21,074	1,820	0	655	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,116	2,437	0	287	0
59.00	05900	CARDIAC CATHETERIZATION	13,673	3,390	133	2,430	0
60.00	06000	LABORATORY	143,704	10,578	4	4,492	0
65.00	06500	RESPIRATORY THERAPY	18,719	1,843	0	437	0
66.00	06600	PHYSICAL THERAPY	38,898	9,217	293	4,710	0
67.00	06700	OCCUPATIONAL THERAPY	7,175	0	0	68	0
68.00	06800	SPEECH PATHOLOGY	8,482	3,008	4	478	0
69.00	06900	ELECTROCARDIOLOGY	21,549	6,839	147	2,730	0
70.00	07000	ELECTROENCEPHALOGRAPHY	10,778	5,477	37	1,884	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,585	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	66,127	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	106,611	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,622	3,243	0	1,119	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,622	16,991	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	11,519	8,280	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	14,202	3,377	0	0	0
91.00	09100	EMERGENCY	104,008	10,717	2,629	14,376	2,469
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	61,416	3,908	0	532	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	31,128	2,791	0	956	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,515,400	261,662	16,092	85,859	114,480
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	556,952	105,944	16	19,154	0
194.00	07950	WELLNESS	7,245	0	1	423	0
194.02	07951	LIFELINE	2,500	286	0	0	0
194.03	07952	OCCUPATIONAL HEALTH	6,349	3,472	1	1,147	0
194.05	07954	MISC. NONREIMBURSABLE	37,082	21,935	0	2,471	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,125,528	393,299	16,110	109,054	114,480

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet B Part II Date/Time Prepared: 11/22/2013 2:52 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	105,560					11.00
13.00	01300	2,201	43,766				13.00
14.00	01400	1,431	0	257,624			14.00
15.00	01500	1,981	0	0	75,087		15.00
16.00	01600	4,403	0	0	0	72,645	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,485	19,386	0	0	4,020	30.00
32.00	03200	2,201	2,241	0	0	486	32.00
40.00	04000	2,532	2,173	0	0	603	40.00
43.00	04300	771	783	0	0	233	43.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,246	9,458	0	0	8,245	50.00
51.00	05100	1,321	1,329	0	0	820	51.00
52.00	05200	1,101	1,134	0	0	717	52.00
53.00	05300	2,312	449	0	0	1,560	53.00
54.00	05400	2,862	0	0	0	3,867	54.00
55.00	05500	1,761	0	0	0	1,731	55.00
56.00	05600	1,431	0	0	0	3,268	56.00
57.00	05700	660	0	0	0	6,183	57.00
58.00	05800	440	0	0	0	2,627	58.00
59.00	05900	660	0	0	0	675	59.00
60.00	06000	9,356	0	0	0	7,958	60.00
65.00	06500	1,871	0	0	0	1,277	65.00
66.00	06600	2,642	0	0	0	1,589	66.00
67.00	06700	550	0	0	0	260	67.00
68.00	06800	1,211	0	0	0	314	68.00
69.00	06900	2,201	0	0	0	897	69.00
70.00	07000	220	0	0	0	897	70.00
71.00	07100	0	0	115,931	0	3,613	71.00
72.00	07200	0	0	141,693	0	2,953	72.00
73.00	07300	0	0	0	75,087	9,106	73.00
75.00	07500	0	0	0	0	0	75.00
76.00	03020	1,211	0	0	0	37	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	69	88.00
88.01	08801	0	0	0	0	94	88.01
88.02	08802	0	0	0	0	163	88.02
91.00	09100	7,815	6,813	0	0	6,499	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,211	0	0	0	916	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	440	0	0	0	968	116.00
118.00		85,527	43,766	257,624	75,087	72,645	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	17,061	0	0	0	0	192.00
194.00	07950	660	0	0	0	0	194.00
194.02	07951	110	0	0	0	0	194.02
194.03	07952	881	0	0	0	0	194.03
194.05	07954	1,321	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		105,560	43,766	257,624	75,087	72,645	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140189

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

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	821,821	0	821,821	30.00
32.00	03200	113,425	0	113,425	32.00
40.00	04000	148,710	0	148,710	40.00
43.00	04300	28,647	0	28,647	43.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,517,488	0	1,517,488	50.00
51.00	05100	44,426	0	44,426	51.00
52.00	05200	104,581	0	104,581	52.00
53.00	05300	127,245	0	127,245	53.00
54.00	05400	1,089,715	0	1,089,715	54.00
55.00	05500	408,014	0	408,014	55.00
56.00	05600	300,890	0	300,890	56.00
57.00	05700	390,455	0	390,455	57.00
58.00	05800	429,523	0	429,523	58.00
59.00	05900	272,491	0	272,491	59.00
60.00	06000	666,365	0	666,365	60.00
65.00	06500	88,965	0	88,965	65.00
66.00	06600	204,140	0	204,140	66.00
67.00	06700	18,255	0	18,255	67.00
68.00	06800	55,822	0	55,822	68.00
69.00	06900	202,652	0	202,652	69.00
70.00	07000	98,423	0	98,423	70.00
71.00	07100	170,129	0	170,129	71.00
72.00	07200	210,773	0	210,773	72.00
73.00	07300	190,804	0	190,804	73.00
75.00	07500	0	0	0	75.00
76.00	03020	38,890	0	38,890	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	135,033	0	135,033	88.00
88.01	08801	71,565	0	71,565	88.01
88.02	08802	42,301	0	42,301	88.02
91.00	09100	321,613	0	321,613	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	101,005	0	101,005	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	47,289	0	47,289	116.00
118.00		8,461,455	0	8,461,455	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	1,591,707	0	1,591,707	192.00
194.00	07950	10,688	0	10,688	194.00
194.02	07951	4,602	0	4,602	194.02
194.03	07952	37,811	0	37,811	194.03
194.05	07954	398,574	0	398,574	194.05
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		10,504,837	0	10,504,837	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	446,076					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		5,967,561				2.00
4.00 00400	EMPLOYEE BENEFITS	3,658	7,379	97,801,480			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	64,068	1,353,989	11,283,030	-27,465,166	146,929,266	5.00
7.00 00700	OPERATION OF PLANT	31,730	83,667	989,278	0	4,561,789	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,062	0	27,288	0	507,589	8.00
9.00 00900	HOUSEKEEPING	9,279	5,759	1,257,333	0	1,965,769	9.00
10.00 01000	DIETARY	6,564	33,736	577,477	0	1,282,235	10.00
11.00 01100	CAFETERIA	3,973	43,676	747,620	0	921,144	11.00
13.00 01300	NURSING ADMINISTRATION	1,417	2,788	1,281,674	0	1,756,670	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,379	146,416	408,800	0	1,456,243	14.00
15.00 01500	PHARMACY	2,935	15,417	1,401,856	0	2,017,081	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,184	6,023	1,510,825	0	2,245,879	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	33,491	194,407	9,255,685	0	11,251,567	30.00
32.00 03200	CORONARY CARE UNIT	4,432	31,705	1,142,487	0	1,631,061	32.00
40.00 04000	SUBPROVIDER - IPF	8,717	17,909	2,284,603	0	1,899,613	40.00
43.00 04300	NURSERY	617	11,923	365,910	0	469,670	43.00
45.00 04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	34,982	853,566	4,369,451	0	8,224,637	50.00
51.00 05100	RECOVERY ROOM	1,573	9,967	688,400	0	980,759	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,407	62,839	555,290	0	827,152	52.00
53.00 05300	ANESTHESIOLOGY	646	71,123	5,326,776	0	1,931,178	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,536	739,050	1,641,147	0	3,802,581	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	6,842	257,182	1,779,961	0	1,867,606	55.00
56.00 05600	RADIOISOTOPE	1,948	194,407	1,097,922	0	2,687,255	56.00
57.00 05700	CT SCAN	1,526	283,159	360,728	0	1,456,810	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	321,221	277,033	0	906,697	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,842	187,612	381,348	0	945,161	59.00
60.00 06000	LABORATORY	8,868	345,636	4,244,153	0	9,933,891	60.00
65.00 06500	RESPIRATORY THERAPY	1,545	43,486	833,491	0	1,294,029	65.00
66.00 06600	PHYSICAL THERAPY	14,378	36,345	1,594,624	0	2,688,910	66.00
67.00 06700	OCCUPATIONAL THERAPY	422	5,754	365,674	0	496,025	67.00
68.00 06800	SPEECH PATHOLOGY	3,094	16,427	692,485	0	586,374	68.00
69.00 06900	ELECTROCARDIOLOGY	5,733	103,373	1,073,238	0	1,489,644	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4,591	37,810	353,416	0	745,072	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,496,835	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	4,571,186	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,369,782	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	4,321	431,202	0	596,022	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	14,244	7,945	265,855	0	526,883	88.00
88.01 08801	RURAL HEALTH CLINIC II	6,941	2,063	491,245	0	796,270	88.01
88.02 08802	RURAL HEALTH CLINIC III	2,831	3,525	689,360	0	981,781	88.02
91.00 09100	EMERGENCY	8,984	81,648	6,281,032	0	7,189,807	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	3,990	3,111	2,928,806	0	4,245,541	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	1,500	0	1,197,406	0	2,151,813	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	328,691	5,626,364	70,453,909	-27,465,166	104,756,011	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	95,846	168,332	25,337,781	0	38,497,316	192.00
194.00 07950	WELLNESS	0	1,847	225,812	0	500,855	194.00
194.02 07951	LIFELINE	240	0	37,770	0	172,792	194.02
194.03 07952	OCCUPATIONAL HEALTH	2,911	4,283	418,448	0	438,925	194.03
194.05 07954	MISC. NONREIMBURSABLE	18,388	166,735	1,327,760	0	2,563,367	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,146,048	7,358,789	20,337,520		27,465,166	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.052717	1.233132	0.207947		0.186928	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			34,898		2,125,528	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000357		0.014466	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	329,706				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	800,420			8.00
9.00	00900	HOUSEKEEPING	6,391	0	7,988		9.00
10.00	01000	DIETARY	6,564	0	0	126,991	10.00
11.00	01100	CAFETERIA	3,973	9,435	378	0	959 11.00
13.00	01300	NURSING ADMINISTRATION	1,417	0	42	0	20 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	17,150	109	0	13 14.00
15.00	01500	PHARMACY	2,635	0	42	0	18 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,011	0	40	0	40 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,491	275,875	128	99,478	177 30.00
32.00	03200	CORONARY CARE UNIT	4,432	23,026	275	5,143	20 32.00
40.00	04000	SUBPROVIDER - I/PF	8,717	13,238	361	17,694	23 40.00
43.00	04300	NURSERY	617	7,145	0	0	7 43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	34,982	160,517	1,759	1,937	84 50.00
51.00	05100	RECOVERY ROOM	1,573	21,264	61	0	12 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	18,636	0	0	10 52.00
53.00	05300	ANESTHESIOLOGY	646	0	4	0	21 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,536	80,543	206	0	26 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,842	11,389	226	0	16 55.00
56.00	05600	RADIOISOTOPE	1,948	0	83	0	13 56.00
57.00	05700	CT SCAN	1,526	0	48	0	6 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	0	21	0	4 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	6,612	178	0	6 59.00
60.00	06000	LABORATORY	8,868	200	329	0	85 60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	32	0	17 65.00
66.00	06600	PHYSICAL THERAPY	7,727	14,544	345	0	24 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5	0	5 67.00
68.00	06800	SPEECH PATHOLOGY	2,522	210	35	0	11 68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	7,320	200	0	20 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	1,814	138	0	2 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	82	0	11 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,244	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	6,941	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	2,831	0	0	0	0 88.02
91.00	09100	EMERGENCY	8,984	130,621	1,053	2,739	71 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,276	0	39	0	11 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	2,340	0	70	0	4 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	219,355	799,539	6,289	126,991	777 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,812	789	1,403	0	155 192.00
194.00	07950	WELLNESS	0	66	31	0	6 194.00
194.02	07951	LIFELINE	240	0	0	0	1 194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	26	84	0	8 194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	0	181	0	12 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,414,515	619,912	2,438,181	1,629,717	1,281,262 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.422252	0.774483	305.230471	12.833327	1,336.039625 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	393,299	16,110	109,054	114,480	105,560 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.192878	0.020127	13.652228	0.901481	110.072993 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	709,960				13.00
14.00	01400	0	10,000			14.00
15.00	01500	0	0	10,000		15.00
16.00	01600	0	0	0	435,285,183	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	314,493	0	0	24,070,708	30.00
32.00	03200	36,358	0	0	2,909,886	32.00
40.00	04000	35,253	0	0	3,608,914	40.00
43.00	04300	12,699	0	0	1,397,188	43.00
45.00	04500	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	153,418	0	0	49,371,554	50.00
51.00	05100	21,551	0	0	4,907,551	51.00
52.00	05200	18,390	0	0	4,296,261	52.00
53.00	05300	7,281	0	0	9,342,946	53.00
54.00	05400	0	0	0	23,156,115	54.00
55.00	05500	0	0	0	10,367,083	55.00
56.00	05600	0	0	0	19,568,829	56.00
57.00	05700	0	0	0	37,021,168	57.00
58.00	05800	0	0	0	15,730,557	58.00
59.00	05900	0	0	0	4,043,966	59.00
60.00	06000	0	0	0	47,654,151	60.00
65.00	06500	0	0	0	7,648,871	65.00
66.00	06600	0	0	0	9,512,017	66.00
67.00	06700	0	0	0	1,555,171	67.00
68.00	06800	0	0	0	1,879,885	68.00
69.00	06900	0	0	0	5,372,711	69.00
70.00	07000	0	0	0	5,372,950	70.00
71.00	07100	0	4,500	0	21,632,491	71.00
72.00	07200	0	5,500	0	17,679,822	72.00
73.00	07300	0	0	10,000	54,817,954	73.00
75.00	07500	0	0	0	0	75.00
76.00	03020	0	0	0	221,621	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	412,657	88.00
88.01	08801	0	0	0	563,239	88.01
88.02	08802	0	0	0	974,321	88.02
91.00	09100	110,517	0	0	38,915,723	91.00
92.00	09200	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	5,482,083	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	5,796,790	116.00
118.00		709,960	10,000	10,000	435,285,183	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.02	07951	0	0	0	0	194.02
194.03	07952	0	0	0	0	194.03
194.05	07954	0	0	0	0	194.05
200.00						200.00
201.00						201.00
202.00		2,147,852	1,897,135	2,474,272	2,797,218	202.00
203.00		3.025314	189.713500	247.427200	0.006426	203.00
204.00		43,766	257,624	75,087	72,645	204.00
205.00		0.061646	25.762400	7.508700	0.000167	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet C Part I Date/Time Prepared: 11/22/2013 2:52 pm	
		Title XVIII		Hospital		PPS	
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		16,776,761	98,316	16,875,077	30.00	
32.00	03200 CORONARY CARE UNIT		2,331,922	0	2,331,922	32.00	
40.00	04000 SUBPROVIDER - I/PF		2,905,942	0	2,905,942	40.00	
43.00	04300 NURSERY		629,879	0	629,879	43.00	
45.00	04500 NURSING FACILITY		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		11,916,239	0	11,916,239	50.00	
51.00	05100 RECOVERY ROOM		1,337,777	0	1,337,777	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,115,913	0	1,115,913	52.00	
53.00	05300 ANESTHESIOLOGY		2,414,121	245,147	2,659,268	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,044,476	0	5,044,476	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		2,494,874	0	2,494,874	55.00	
56.00	05600 RADIOISOTOPE		3,390,021	0	3,390,021	56.00	
57.00	05700 CT SCAN		2,014,754	0	2,014,754	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,222,574	0	1,222,574	58.00	
59.00	05900 CARDIAC CATHETERIZATION		1,261,965	0	1,261,965	59.00	
60.00	06000 LABORATORY		12,456,811	23,260	12,480,071	60.00	
65.00	06500 RESPIRATORY THERAPY	0	1,642,923	0	1,642,923	65.00	
66.00	06600 PHYSICAL THERAPY	0	3,528,196	0	3,528,196	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	606,946	0	606,946	67.00	
68.00	06800 SPEECH PATHOLOGY	0	775,023	0	775,023	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,990,210	0	1,990,210	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		1,040,468	0	1,040,468	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		5,143,212	0	5,143,212	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		6,582,704	0	6,582,704	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		11,574,007	0	11,574,007	73.00	
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00	
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		793,236	0	793,236	76.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		861,943	0	861,943	88.00	
88.01	08801 RURAL HEALTH CLINIC II		1,062,721	0	1,062,721	88.01	
88.02	08802 RURAL HEALTH CLINIC III		1,218,055	0	1,218,055	88.02	
91.00	09100 EMERGENCY		9,818,323	198,888	10,017,211	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,148,511	0	3,148,511	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		5,154,778	0	5,154,778	101.00	
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE		2,656,435	0	2,656,435	116.00	
200.00	Subtotal (see instructions)	0	124,911,720	565,611	125,477,331	200.00	
201.00	Less Observation Beds		3,148,511	0	3,148,511	201.00	
202.00	Total (see instructions)	0	121,763,209	565,611	122,328,820	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet C Part I Date/Time Prepared: 11/22/2013 2:52 pm	
			Title XVII I		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,274,656		18,274,656			30.00
32.00	03200	CORONARY CARE UNIT	2,909,886		2,909,886			32.00
40.00	04000	SUBPROVIDER - IPF	3,608,914		3,608,914			40.00
43.00	04300	NURSERY	1,397,188		1,397,188			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,463,644	38,907,910	49,371,554	0.241358	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,671,948	3,235,603	4,907,551	0.272596	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,043,024	253,237	4,296,261	0.259741	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,096,686	6,246,260	9,342,946	0.258390	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,806,488	19,349,627	23,156,115	0.217846	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	161,218	10,205,865	10,367,083	0.240653	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,525,247	17,043,582	19,568,829	0.173236	0.000000	56.00
57.00	05700	CT SCAN	6,800,418	30,220,750	37,021,168	0.054422	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	891,589	14,838,968	15,730,557	0.077720	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,044,286	2,999,680	4,043,966	0.312061	0.000000	59.00
60.00	06000	LABORATORY	8,882,301	38,771,850	47,654,151	0.261400	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,044,172	1,604,699	7,648,871	0.214793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	918,465	8,593,552	9,512,017	0.370920	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	230,628	1,324,543	1,555,171	0.390276	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	159,184	1,720,701	1,879,885	0.412271	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,128,055	4,244,656	5,372,711	0.370429	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,024	5,345,926	5,372,950	0.193649	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,598,775	14,033,716	21,632,491	0.237754	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,787,640	3,892,182	17,679,822	0.372329	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,197,143	34,620,811	54,817,954	0.211135	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	221,621	221,621	3.579246	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	412,657	412,657			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	563,239	563,239			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	974,321	974,321			88.02
91.00	09100	EMERGENCY	7,434,710	31,481,013	38,915,723	0.252297	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,796,052	5,796,052	0.543216	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	5,482,083	5,482,083			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	5,796,790	5,796,790			116.00
200.00		Subtotal (see instructions)	127,103,289	308,181,894	435,285,183			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	127,103,289	308,181,894	435,285,183			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/22/2013 2:52 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.241358		50.00
51.00	05100 RECOVERY ROOM	0.272596		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.259741		52.00
53.00	05300 ANESTHESIOLOGY	0.284628		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217846		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.240653		55.00
56.00	05600 RADIOISOTOPE	0.173236		56.00
57.00	05700 CT SCAN	0.054422		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077720		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.312061		59.00
60.00	06000 LABORATORY	0.261888		60.00
65.00	06500 RESPIRATORY THERAPY	0.214793		65.00
66.00	06600 PHYSICAL THERAPY	0.370920		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390276		67.00
68.00	06800 SPEECH PATHOLOGY	0.412271		68.00
69.00	06900 ELECTROCARDIOLOGY	0.370429		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.193649		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237754		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.372329		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211135		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.579246		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
88.02	08802 RURAL HEALTH CLINIC III			88.02
91.00	09100 EMERGENCY	0.257408		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.543216		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
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		Provi der CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet C Part I Date/Time Prepared: 11/22/2013 2: 52 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	16,776,761		16,776,761	0	0	30.00
32.00	03200 CORONARY CARE UNIT	2,331,922		2,331,922	0	0	32.00
40.00	04000 SUBPROVIDER - I PF	2,905,942		2,905,942	0	0	40.00
43.00	04300 NURSERY	629,879		629,879	0	0	43.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,916,239		11,916,239	0	0	50.00
51.00	05100 RECOVERY ROOM	1,337,777		1,337,777	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,115,913		1,115,913	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2,414,121		2,414,121	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,044,476		5,044,476	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,494,874		2,494,874	0	0	55.00
56.00	05600 RADIOISOTOPE	3,390,021		3,390,021	0	0	56.00
57.00	05700 CT SCAN	2,014,754		2,014,754	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,222,574		1,222,574	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,261,965		1,261,965	0	0	59.00
60.00	06000 LABORATORY	12,456,811		12,456,811	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,642,923	0	1,642,923	0	0	65.00
66.00	06600 PHYSICAL THERAPY	3,528,196	0	3,528,196	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	606,946	0	606,946	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	775,023	0	775,023	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,990,210		1,990,210	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,040,468		1,040,468	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,143,212		5,143,212	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,582,704		6,582,704	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,574,007		11,574,007	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	793,236		793,236	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	861,943		861,943	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,062,721		1,062,721	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	1,218,055		1,218,055	0	0	88.02
91.00	09100 EMERGENCY	9,818,323		9,818,323	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,148,511		3,148,511	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	5,154,778		5,154,778		0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	2,656,435		2,656,435		0	116.00
200.00	Subtotal (see instructions)	124,911,720	0	124,911,720	0	0	200.00
201.00	Less Observation Beds	3,148,511		3,148,511		0	201.00
202.00	Total (see instructions)	121,763,209	0	121,763,209	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet C Part I Date/Time Prepared: 11/22/2013 2:52 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,274,656		18,274,656			30.00
32.00	03200	CORONARY CARE UNIT	2,909,886		2,909,886			32.00
40.00	04000	SUBPROVIDER - IPF	3,608,914		3,608,914			40.00
43.00	04300	NURSERY	1,397,188		1,397,188			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,463,644	38,907,910	49,371,554	0.241358	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,671,948	3,235,603	4,907,551	0.272596	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,043,024	253,237	4,296,261	0.259741	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,096,686	6,246,260	9,342,946	0.258390	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,806,488	19,349,627	23,156,115	0.217846	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	161,218	10,205,865	10,367,083	0.240653	0.000000	55.00
56.00	05600	RADIOISOTOPE	2,525,247	17,043,582	19,568,829	0.173236	0.000000	56.00
57.00	05700	CT SCAN	6,800,418	30,220,750	37,021,168	0.054422	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	891,589	14,838,968	15,730,557	0.077720	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,044,286	2,999,680	4,043,966	0.312061	0.000000	59.00
60.00	06000	LABORATORY	8,882,301	38,771,850	47,654,151	0.261400	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,044,172	1,604,699	7,648,871	0.214793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	918,465	8,593,552	9,512,017	0.370920	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	230,628	1,324,543	1,555,171	0.390276	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	159,184	1,720,701	1,879,885	0.412271	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,128,055	4,244,656	5,372,711	0.370429	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,024	5,345,926	5,372,950	0.193649	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,598,775	14,033,716	21,632,491	0.237754	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,787,640	3,892,182	17,679,822	0.372329	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,197,143	34,620,811	54,817,954	0.211135	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	221,621	221,621	3.579246	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	412,657	412,657	2.088764	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	563,239	563,239	1.886803	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	974,321	974,321	1.250158	0.000000	88.02
91.00	09100	EMERGENCY	7,434,710	31,481,013	38,915,723	0.252297	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,796,052	5,796,052	0.543216	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	5,482,083	5,482,083			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	5,796,790	5,796,790			116.00
200.00		Subtotal (see instructions)	127,103,289	308,181,894	435,285,183			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	127,103,289	308,181,894	435,285,183			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/22/2013 2:52 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
45.00	04500 NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
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
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/22/2013 2:52 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	821,821	0	821,821	21,814	37.67	30.00
32.00	CORONARY CARE UNIT	113,425		113,425	1,777	63.83	32.00
40.00	SUBPROVIDER - IPF	148,710	0	148,710	3,423	43.44	40.00
43.00	NURSERY	28,647		28,647	1,194	23.99	43.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	1,112,603		1,112,603	28,208		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,404	391,919				
32.00	CORONARY CARE UNIT	996	63,575				
40.00	SUBPROVIDER - IPF	1,053	45,742				
43.00	NURSERY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	12,453	501,236				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/22/2013 2:52 pm
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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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
Title VIII								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,517,488	49,371,554	0.030736	5,113,164	157,158	50.00
51.00	05100	RECOVERY ROOM	44,426	4,907,551	0.009053	635,073	5,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,581	4,296,261	0.024342	6,139	149	52.00
53.00	05300	ANESTHESIOLOGY	127,245	9,342,946	0.013619	1,318,965	17,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,089,715	23,156,115	0.047059	2,730,650	128,502	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	408,014	10,367,083	0.039357	101,394	3,991	55.00
56.00	05600	RADIOISOTOPE	300,890	19,568,829	0.015376	1,114,823	17,142	56.00
57.00	05700	CT SCAN	390,455	37,021,168	0.010547	4,118,337	43,436	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	429,523	15,730,557	0.027305	489,265	13,359	58.00
59.00	05900	CARDIAC CATHETERIZATION	272,491	4,043,966	0.067382	447,279	30,139	59.00
60.00	06000	LABORATORY	666,365	47,654,151	0.013983	5,274,803	73,758	60.00
65.00	06500	RESPIRATORY THERAPY	88,965	7,648,871	0.011631	3,547,960	41,266	65.00
66.00	06600	PHYSICAL THERAPY	204,140	9,512,017	0.021461	536,574	11,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,255	1,555,171	0.011738	157,648	1,850	67.00
68.00	06800	SPEECH PATHOLOGY	55,822	1,879,885	0.029694	78,032	2,317	68.00
69.00	06900	ELECTROCARDIOLOGY	202,652	5,372,711	0.037719	682,603	25,747	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	98,423	5,372,950	0.018318	11,710	215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,129	21,632,491	0.007865	3,825,898	30,091	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	210,773	17,679,822	0.011922	7,219,026	86,065	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,804	54,817,954	0.003481	11,111,355	38,679	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	38,890	221,621	0.175480	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	135,033	412,657	0.327228	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	71,565	563,239	0.127060	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	42,301	974,321	0.043416	0	0	88.02
91.00	09100	EMERGENCY	321,613	38,915,723	0.008264	4,111,618	33,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	153,332	5,796,052	0.026455	0	0	92.00
200.00		Total (lines 50-199)	7,353,890	397,815,666		52,632,316	763,069	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/22/2013 2:52 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,814	0.00	10,404	0		30.00
32.00	03200	CORONARY CARE UNIT	1,777	0.00	996	0		32.00
40.00	04000	SUBPROVIDER - IPF	3,423	0.00	1,053	0		40.00
43.00	04300	NURSERY	1,194	0.00	0	0		43.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	28,208		12,453	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Title XVIII				Hospital		PPS
		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	
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00	
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	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00	
57.00	05700	CT SCAN	0	0	0	0	0 57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00	
60.00	06000	LABORATORY	0	0	0	0	0 60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00	
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02	
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: 140189

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2013 2:52 pm

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	49,371,554	0.000000	0.000000	5,113,164	50.00
51.00	05100	RECOVERY ROOM	0	4,907,551	0.000000	0.000000	635,073	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,296,261	0.000000	0.000000	6,139	52.00
53.00	05300	ANESTHESIOLOGY	0	9,342,946	0.000000	0.000000	1,318,965	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,156,115	0.000000	0.000000	2,730,650	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,367,083	0.000000	0.000000	101,394	55.00
56.00	05600	RADIOISOTOPE	0	19,568,829	0.000000	0.000000	1,114,823	56.00
57.00	05700	CT SCAN	0	37,021,168	0.000000	0.000000	4,118,337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,730,557	0.000000	0.000000	489,265	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,043,966	0.000000	0.000000	447,279	59.00
60.00	06000	LABORATORY	0	47,654,151	0.000000	0.000000	5,274,803	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,648,871	0.000000	0.000000	3,547,960	65.00
66.00	06600	PHYSICAL THERAPY	0	9,512,017	0.000000	0.000000	536,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,555,171	0.000000	0.000000	157,648	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,879,885	0.000000	0.000000	78,032	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,372,711	0.000000	0.000000	682,603	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,372,950	0.000000	0.000000	11,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,632,491	0.000000	0.000000	3,825,898	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,679,822	0.000000	0.000000	7,219,026	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	54,817,954	0.000000	0.000000	11,111,355	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	221,621	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	412,657	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	563,239	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	974,321	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	38,915,723	0.000000	0.000000	4,111,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,796,052	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	397,815,666			52,632,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,595,540	6,188,778	0	0 50.00
51.00	05100	RECOVERY ROOM	0	584,446	628,367	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	259	518	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	938,022	922,054	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,855,148	3,436,685	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,203,753	3,109,869	0	0 55.00
56.00	05600	RADIOISOTOPE	0	1,985,797	2,591,626	0	0 56.00
57.00	05700	CT SCAN	0	4,709,909	5,713,280	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,056,258	2,361,662	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	421,075	655,191	0	0 59.00
60.00	06000	LABORATORY	0	994,289	711,031	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	267,098	326,822	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	27,388	197,766	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	103,403	100,010	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	802,696	1,127,549	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	741,855	448,492	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,463,524	1,785,308	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	654,039	749,320	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,488,973	8,464,078	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
91.00	09100	EMERGENCY	0	2,988,244	3,179,187	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,290,512	1,610,072	0	0 92.00
200.00		Total (Lines 50-199)	0	39,172,228	44,307,665	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.241358	5,595,540	6,188,778	0	0	50.00
51.00	05100	RECOVERY ROOM	0.272596	584,446	628,367	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.259741	259	518	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.258390	938,022	922,054	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217846	2,855,148	3,436,685	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.240653	3,203,753	3,109,869	0	0	55.00
56.00	05600	RADIOISOTOPE	0.173236	1,985,797	2,591,626	0	0	56.00
57.00	05700	CT SCAN	0.054422	4,709,909	5,713,280	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077720	2,056,258	2,361,662	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.312061	421,075	655,191	0	0	59.00
60.00	06000	LABORATORY	0.261400	994,289	711,031	3,965	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.214793	267,098	326,822	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.370920	27,388	197,766	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390276	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.412271	103,403	100,010	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.370429	802,696	1,127,549	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.193649	741,855	448,492	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237754	1,463,524	1,785,308	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.372329	654,039	749,320	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211135	7,488,973	8,464,078	0	27,714	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.579246	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000					88.02
91.00	09100	EMERGENCY	0.252297	2,988,244	3,179,187	175	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.543216	1,290,512	1,610,072	0	0	92.00
200.00		Subtotal (see instructions)		39,172,228	44,307,665	4,140	27,714	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		39,172,228	44,307,665	4,140	27,714	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140189

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

Worksheet D
Part V
Date/Time Prepared:
11/22/2013 2:52 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Costs					
			PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,350,528	1,493,711	0	0		50.00
51.00	05100	RECOVERY ROOM	159,318	171,290	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67	135	0	0		52.00
53.00	05300	ANESTHESIOLOGY	242,376	238,250	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	621,983	748,668	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	770,993	748,399	0	0		55.00
56.00	05600	RADIOISOTOPE	344,012	448,963	0	0		56.00
57.00	05700	CT SCAN	256,323	310,928	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,812	183,548	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	131,401	204,460	0	0		59.00
60.00	06000	LABORATORY	259,907	185,864	1,036	0		60.00
65.00	06500	RESPIRATORY THERAPY	57,371	70,199	0	0		65.00
66.00	06600	PHYSICAL THERAPY	10,159	73,355	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	42,630	41,231	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	297,342	417,677	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	143,659	86,850	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	347,959	424,464	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	243,518	278,994	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,581,184	1,787,063	0	5,851		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0		88.02
91.00	09100	EMERGENCY	753,925	802,099	44	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	701,027	874,617	0	0		92.00
200.00		Subtotal (see instructions)	8,475,494	9,590,765	1,080	5,851		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 +/- line 201)	8,475,494	9,590,765	1,080	5,851		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/22/2013 2:52 pm	
				Title XVIII		Subprovider - IPF	PPS
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	1,517,488	49,371,554	0.030736	0	0 50.00
51.00	05100	RECOVERY ROOM	44,426	4,907,551	0.009053	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,581	4,296,261	0.024342	0	0 52.00
53.00	05300	ANESTHESIOLOGY	127,245	9,342,946	0.013619	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,089,715	23,156,115	0.047059	9,533	449 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	408,014	10,367,083	0.039357	11,123	438 55.00
56.00	05600	RADIOISOTOPE	300,890	19,568,829	0.015376	0	0 56.00
57.00	05700	CT SCAN	390,455	37,021,168	0.010547	23,744	250 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	429,523	15,730,557	0.027305	25,729	703 58.00
59.00	05900	CARDIAC CATHETERIZATION	272,491	4,043,966	0.067382	0	0 59.00
60.00	06000	LABORATORY	666,365	47,654,151	0.013983	202,729	2,835 60.00
65.00	06500	RESPIRATORY THERAPY	88,965	7,648,871	0.011631	66,888	778 65.00
66.00	06600	PHYSICAL THERAPY	204,140	9,512,017	0.021461	3,211	69 66.00
67.00	06700	OCCUPATIONAL THERAPY	18,255	1,555,171	0.011738	1,093	13 67.00
68.00	06800	SPEECH PATHOLOGY	55,822	1,879,885	0.029694	584	17 68.00
69.00	06900	ELECTROCARDIOLOGY	202,652	5,372,711	0.037719	35,250	1,330 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	98,423	5,372,950	0.018318	309	6 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,129	21,632,491	0.007865	6,202	49 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	210,773	17,679,822	0.011922	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	190,804	54,817,954	0.003481	349,441	1,216 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0 75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	38,890	221,621	0.175480	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	135,033	412,657	0.327228	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	71,565	563,239	0.127060	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	42,301	974,321	0.043416	0	0 88.02
91.00	09100	EMERGENCY	321,613	38,915,723	0.008264	256,017	2,116 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,796,052	0.000000	0	0 92.00
200.00		Total (lines 50-199)	7,200,558	397,815,666		991,853	10,269 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Subprovider - IPF

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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 2:52 pm
Title XVIII		Subprovider - IPF	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	49,371,554	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	4,907,551	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,296,261	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	9,342,946	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,156,115	0.000000	0.000000	9,533	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,367,083	0.000000	0.000000	11,123	55.00
56.00	05600	RADIOISOTOPE	0	19,568,829	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	37,021,168	0.000000	0.000000	23,744	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	15,730,557	0.000000	0.000000	25,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,043,966	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	47,654,151	0.000000	0.000000	202,729	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,648,871	0.000000	0.000000	66,888	65.00
66.00	06600	PHYSICAL THERAPY	0	9,512,017	0.000000	0.000000	3,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,555,171	0.000000	0.000000	1,093	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,879,885	0.000000	0.000000	584	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,372,711	0.000000	0.000000	35,250	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,372,950	0.000000	0.000000	309	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,632,491	0.000000	0.000000	6,202	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,679,822	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	54,817,954	0.000000	0.000000	349,441	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	221,621	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	412,657	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	563,239	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	974,321	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	38,915,723	0.000000	0.000000	256,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,796,052	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	397,815,666			991,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/22/2013 2:52 pm
	Component CCN: 14S189	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
	11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 2:52 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,814	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,814	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)		17,744	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)		10,404	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		16,875,077	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)		16,875,077	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		18,274,656	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		18,274,656	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.923414	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,029.91	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)		16,875,077	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)		773.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,048,430	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)		8,048,430	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 2:52 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	2,331,922	1,777	1,312.28	996	1,307,031	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)					12,691,517	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,046,978	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)					455,494	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					763,069	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,218,563	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,828,415	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					4,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					773.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,148,511	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/22/2013 2:52 pm	
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	821,821	16,875,077	0.048700	3,148,511	153,332	90.00
91.00	Nursing School cost	0	16,875,077	0.000000	3,148,511	0	91.00
92.00	Allied health cost	0	16,875,077	0.000000	3,148,511	0	92.00
93.00	All other Medical Education	0	16,875,077	0.000000	3,148,511	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1
		Component CCN: 14S189		Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Subprovider - IPF	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)		3,423	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,423	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)		3,423	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,053	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	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)		2,905,942	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)		2,905,942	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,608,914	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,608,914	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.805212	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,054.31	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)		2,905,942	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)		848.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		893,944	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)		893,944	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
		Component CCN: 14S189				Date/Time Prepared: 11/22/2013 2:52 pm	
		Title XVIII		Subprovider - IPF		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)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	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)					231,637		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,125,581		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)					45,742		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,269		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					56,011		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,069,570		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					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: 140189 Component CCN: 14S189		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/22/2013 2:52 pm	
		Title XVIII		Subprovider - IPF		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	148,710	2,905,942	0.051174	0	0	90.00
91.00	Nursing School cost	0	2,905,942	0.000000	0	0	91.00
92.00	Allied health cost	0	2,905,942	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,905,942	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/22/2013 2:52 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		10,469,119	30.00
32.00	03200	CORONARY CARE UNIT		1,606,866	32.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.241358	5,113,164	50.00
51.00	05100	RECOVERY ROOM	0.272596	635,073	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.259741	6,139	52.00
53.00	05300	ANESTHESIOLOGY	0.284628	1,318,965	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217846	2,730,650	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.240653	101,394	55.00
56.00	05600	RADIOISOTOPE	0.173236	1,114,823	56.00
57.00	05700	CT SCAN	0.054422	4,118,337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.077720	489,265	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.312061	447,279	59.00
60.00	06000	LABORATORY	0.261888	5,274,803	60.00
65.00	06500	RESPIRATORY THERAPY	0.214793	3,547,960	65.00
66.00	06600	PHYSICAL THERAPY	0.370920	536,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390276	157,648	67.00
68.00	06800	SPEECH PATHOLOGY	0.412271	78,032	68.00
69.00	06900	ELECTROCARDIOLOGY	0.370429	682,603	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.193649	11,710	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237754	3,825,898	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.372329	7,219,026	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.211135	11,111,355	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.579246	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.257408	4,111,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.543216	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		52,632,316	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)		52,632,316	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
		Component CCN: 14S189		Date/Time Prepared: 11/22/2013 2:52 pm	
		Title XVIII	Subprovider - IPF	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
32.00	03200 CORONARY CARE UNIT		0		32.00
40.00	04000 SUBPROVIDER - IPF		1,103,648		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.241358	0	0	50.00
51.00	05100 RECOVERY ROOM	0.272596	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.259741	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.284628	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.217846	9,533	2,077	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.240653	11,123	2,677	55.00
56.00	05600 RADIOISOTOPE	0.173236	0	0	56.00
57.00	05700 CT SCAN	0.054422	23,744	1,292	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077720	25,729	2,000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.312061	0	0	59.00
60.00	06000 LABORATORY	0.261888	202,729	53,092	60.00
65.00	06500 RESPIRATORY THERAPY	0.214793	66,888	14,367	65.00
66.00	06600 PHYSICAL THERAPY	0.370920	3,211	1,191	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390276	1,093	427	67.00
68.00	06800 SPEECH PATHOLOGY	0.412271	584	241	68.00
69.00	06900 ELECTROCARDIOLOGY	0.370429	35,250	13,058	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.193649	309	60	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.237754	6,202	1,475	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.372329	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.211135	349,441	73,779	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.579246	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100 EMERGENCY	0.257408	256,017	65,901	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.543216	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		991,853	231,637	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)		991,853		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		17,537,194	1.00
2.00	Outlier payments for discharges. (see instructions)		344,692	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		77.85	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.31	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.08	31.00
32.00	Sum of lines 30 and 31		19.39	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.64	33.00
34.00	Disproportionate share adjustment (see instructions)		989,098	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		18,870,984	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		21,100,777	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		21,100,777	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,402,329	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		3,750	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,506,856	59.00
60.00	Primary payer payments		7,300	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,499,556	61.00
62.00	Deductibles billed to program beneficiaries		2,242,708	62.00
63.00	Coinsurance billed to program beneficiaries		37,785	63.00
64.00	Allowable bad debts (see instructions)		587,181	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		411,027	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,630,090	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER		0	70.00
70.93	HVBP incentive payment (see instructions)		32,818	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,662,908	71.00
72.00	Interim payments		21,666,261	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		-1,003,353	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,931	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,475,494	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)		6,931	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		31,854	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)		31,854	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 charge basis 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)		31,854	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		24,923	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)		6,931	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)		16,841,144	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)		3,899,855	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)		12,948,220	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)		12,948,220	30.00
31.00	Primary payer payments		1,323	31.00
32.00	Subtotal (line 30 minus line 31)		12,946,897	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)		855,756	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		599,029	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		13,545,926	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-4	38.00
39.00			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		13,545,930	40.00
41.00	Interim payments		14,488,630	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-942,700	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140189

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Title XVIII

Hospital

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		20,601,455		14,500,790	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/10/2013	1,167,674	01/10/2013	55,384	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	06/30/2013	102,868	06/30/2013	67,544	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)		1,064,806		-12,160	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)		21,666,261		14,488,630	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,003,353		942,700	6.02
7.00	Total Medicare program liability (see instructions)		20,662,908		13,545,930	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: 140189
Component CCN: 14S189

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2013 2:52 pm
PPS

Title XVIII

Subprovider -
IPF

		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		698,041		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		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)		698,041		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		99,941		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		797,982		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Hospital	PPS
				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			5,714 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			11,400 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			19,521 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			435,285,183 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			24,739,239 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)			1,352,712 8.00
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 minus line 30 and line 31)			1,352,712 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part II Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			869,646 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9.378082 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			869,646 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			869,646 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			869,646 18.00
19.00	Deductibles			168,368 19.00
20.00	Subtotal (line 18 minus line 19)			701,278 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			701,278 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			132,493 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			92,745 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			794,023 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	IP PSY SEQ AMT PER PS&R			3,959 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			797,982 31.00
32.00	Interim payments			698,041 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			99,941 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 140189

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

Worksheet G

Date/Time Prepared:
11/22/2013 2:52 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	22,774,463	0	0	0	1.00
2.00	Temporary investments	11,245,604	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	72,948,534	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-42,222,852	0	0	0	6.00
7.00	Inventory	3,685,501	0	0	0	7.00
8.00	Prepaid expenses	5,333,408	0	0	0	8.00
9.00	Other current assets	2,404,242	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	76,168,900	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,194,269	0	0	0	12.00
13.00	Land improvements	7,208,158	0	0	0	13.00
14.00	Accumulated depreciation	-3,689,153	0	0	0	14.00
15.00	Buildings	116,573,254	0	0	0	15.00
16.00	Accumulated depreciation	-38,792,354	0	0	0	16.00
17.00	Leasehold improvements	479,836	0	0	0	17.00
18.00	Accumulated depreciation	-115,851	0	0	0	18.00
19.00	Fixed equipment	13,242,498	0	0	0	19.00
20.00	Accumulated depreciation	-10,637,383	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	74,712,311	0	0	0	23.00
24.00	Accumulated depreciation	-57,522,776	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)	104,652,809	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	96,227,110	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	68,485,388	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	164,712,498	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	345,534,207	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,524,907	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,069,049	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,652,308	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,339,120	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	41,585,384	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	80,163,520	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	80,163,520	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	121,748,904	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	223,785,303				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)	223,785,303	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	345,534,207	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140189

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

Worksheet G-1

Date/Time Prepared:
11/22/2013 2:52 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		198,159,944		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		25,625,359			2.00
3.00	Total (sum of line 1 and line 2)		223,785,303		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		223,785,303		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		223,785,303		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: 140189

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,274,656		18,274,656	1.00
2.00	SUBPROVIDER - IPF	3,608,914		3,608,914	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				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	21,883,570		21,883,570	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	2,909,886		2,909,886	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)	2,909,886		2,909,886	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,793,456		24,793,456	17.00
18.00	Ancillary services	100,913,645	264,225,582	365,139,227	18.00
19.00	Outpatient services	0	31,702,634	31,702,634	19.00
20.00	RURAL HEALTH CLINIC	0	412,657	412,657	20.00
20.01	RURAL HEALTH CLINIC II	0	563,239	563,239	20.01
20.02	RURAL HEALTH CLINIC III	0	974,321	974,321	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,482,083	5,482,083	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,796,790	5,796,790	26.00
27.00	NURSERY (INPATIENT REVENUES)	1,397,188	0	1,397,188	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	127,104,289	309,157,306	436,261,595	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		195,790,825		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		195,790,825		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140189

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

Worksheet G-3

Date/Time Prepared:
11/22/2013 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	436,261,595	1.00
2.00	Less contractual allowances and discounts on patients' accounts	267,792,202	2.00
3.00	Net patient revenues (line 1 minus line 2)	168,469,393	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	195,790,825	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-27,321,432	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	135,991	6.00
7.00	Income from investments	12,689,378	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	87,832	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	666,306	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	96,696	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	18,551	21.00
22.00	Rental of hospital space	291,436	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIAN PRACTICE, GRANTS, MISC.	38,960,601	24.00
25.00	Total other income (sum of lines 6-24)	52,946,791	25.00
26.00	Total (line 5 plus line 25)	25,625,359	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,625,359	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet H

HHA CCN: 147594

To 06/30/2013

Date/Time Prepared: 11/22/2013 2:52 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	758,205	208,278	76,537	198,906	192,001	1,433,927	5.00
HHA REIMBURSABLE SERVICES							
6.00	1,417,184	0	0	0	0	1,417,184	6.00
7.00	421,824	0	0	0	0	421,824	7.00
8.00	142,192	0	0	0	0	142,192	8.00
9.00	44,165	0	0	0	0	44,165	9.00
10.00	52,837	0	0	0	0	52,837	10.00
11.00	92,400	0	0	0	0	92,400	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	2,928,807	208,278	76,537	198,906	192,001	3,604,529	24.00
	Reclassifi cation	Reclassifi ed 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	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	1,433,927	0	1,433,927			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	1,417,184	0	1,417,184			6.00
7.00	0	421,824	0	421,824			7.00
8.00	0	142,192	0	142,192			8.00
9.00	0	44,165	0	44,165			9.00
10.00	0	52,837	0	52,837			10.00
11.00	0	92,400	0	92,400			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	3,604,529	0	3,604,529			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: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet H-1 Part I Date/Time Prepared: 11/22/2013 2:52 pm
		HHA CCN: 147594	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
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	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	1,433,927	0	0	0	1,433,927	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,417,184	0	0	0	1,417,184	6.00	
7.00	Physical Therapy	421,824	0	0	0	421,824	7.00	
8.00	Occupational Therapy	142,192	0	0	0	142,192	8.00	
9.00	Speech Pathology	44,165	0	0	0	44,165	9.00	
10.00	Medical Social Services	52,837	0	0	0	52,837	10.00	
11.00	Home Health Aide	92,400	0	0	0	92,400	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	3,604,529	0	0	0	3,604,529	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	1,433,927					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	936,209	2,353,393				6.00	
7.00	Physical Therapy	278,662	700,486				7.00	
8.00	Occupational Therapy	93,934	236,126				8.00	
9.00	Speech Pathology	29,176	73,341				9.00	
10.00	Medical Social Services	34,905	87,742				10.00	
11.00	Home Health Aide	61,041	153,441				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		3,604,529				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet H-1 Part II Date/Time Prepared: 11/22/2013 2:52 pm
		HHA CCN: 147594	Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
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	-1,433,927	2,170,602
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,417,184
7.00	Physical Therapy	0	0	0	0	0	421,824
8.00	Occupational Therapy	0	0	0	0	0	142,192
9.00	Speech Pathology	0	0	0	0	0	44,165
10.00	Medical Social Services	0	0	0	0	0	52,837
11.00	Home Health Aide	0	0	0	0	0	92,400
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,433,927	2,170,602
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,433,927
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.660613

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet H-2

HHA CCN: 147594

To 06/30/2013

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	28,140	3,836	609,036	641,012	119,823	1.00	
2.00 Skilled Nursing Care	2,353,393	0	0	0	2,353,393	439,916	2.00	
3.00 Physical Therapy	700,486	0	0	0	700,486	130,940	3.00	
4.00 Occupational Therapy	236,126	0	0	0	236,126	44,139	4.00	
5.00 Speech Pathology	73,341	0	0	0	73,341	13,709	5.00	
6.00 Medical Social Services	87,742	0	0	0	87,742	16,401	6.00	
7.00 Home Health Aide	153,441	0	0	0	153,441	28,682	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)	3,604,529	28,140	3,836	609,036	4,245,541	793,610	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	53,799	0	11,904	0	14,696	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)	53,799	0	11,904	0	14,696	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet H-2

HHA CCN: 147594

To 06/30/2013

Part I
Date/Time Prepared: 11/22/2013 2:52 pm

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	35,228	876,462	0	876,462	1.00
2.00	Skilled Nursing Care	0	0	0	2,793,309	0	2,793,309	2.00
3.00	Physical Therapy	0	0	0	831,426	0	831,426	3.00
4.00	Occupational Therapy	0	0	0	280,265	0	280,265	4.00
5.00	Speech Pathology	0	0	0	87,050	0	87,050	5.00
6.00	Medical Social Services	0	0	0	104,143	0	104,143	6.00
7.00	Home Health Aide	0	0	0	182,123	0	182,123	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	35,228	5,154,778	0	5,154,778	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	572,242	3,365,551					2.00
3.00	Physical Therapy	170,327	1,001,753					3.00
4.00	Occupational Therapy	57,415	337,680					4.00
5.00	Speech Pathology	17,833	104,883					5.00
6.00	Medical Social Services	21,335	125,478					6.00
7.00	Home Health Aide	37,310	219,433					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) (2)	876,462	5,154,778					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.	0.204861						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: 140189
HHA CCN: 147594

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

Worksheet H-2
Part II
Date/Time Prepared:
11/22/2013 2:52 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	3,990	3,111	2,928,806	0	641,012	3,276	1.00
2.00 Skilled Nursing Care	0	0	0	0	2,353,393	0	2.00
3.00 Physical Therapy	0	0	0	0	700,486	0	3.00
4.00 Occupational Therapy	0	0	0	0	236,126	0	4.00
5.00 Speech Pathology	0	0	0	0	73,341	0	5.00
6.00 Medical Social Services	0	0	0	0	87,742	0	6.00
7.00 Home Health Aide	0	0	0	0	153,441	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)	3,990	3,111	2,928,806		4,245,541	3,276	20.00
21.00 Total cost to be allocated	28,140	3,836	609,036		793,610	53,799	21.00
22.00 Unit cost multiplier	7.052632	1.233044	0.207947		0.186928	16.422161	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	39	0	11	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	39	0	11	0	0	20.00
21.00 Total cost to be allocated	0	11,904	0	14,696	0	0	21.00
22.00 Unit cost multiplier	0.000000	305.230769	0.000000	1,336.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140189
HHA CCN: 147594

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

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	5,482,083		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)	0	5,482,083		20.00
21.00 Total cost to be allocated	0	35,228		21.00
22.00 Unit cost multiplier	0.000000	0.006426		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet H-3 Part I Date/Time Prepared: 11/22/2013 2:52 pm		
				HHA CCN: 147594	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 (col. 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	3,365,551		3,365,551	19,331	174.10	1.00
2.00	Physical Therapy	3.00	1,001,753	0	1,001,753	5,828	171.89	2.00
3.00	Occupational Therapy	4.00	337,680	0	337,680	1,959	172.37	3.00
4.00	Speech Pathology	5.00	104,883	0	104,883	365	287.35	4.00
5.00	Medical Social Services	6.00	125,478		125,478	333	376.81	5.00
6.00	Home Health Aide	7.00	219,433		219,433	3,647	60.17	6.00
7.00	Total (sum of lines 1-6)		5,154,778	0	5,154,778	31,463		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00		4.00 5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	7,673	6,341			8.00
9.00	Physical Therapy		99914	2,818	1,606			9.00
10.00	Occupational Therapy		99914	942	544			10.00
11.00	Speech Pathology		99914	202	98			11.00
12.00	Medical Social Services		99914	135	113			12.00
13.00	Home Health Aide		99914	1,327	2,040			13.00
14.00	Total (sum of lines 8-13)			13,097	10,742			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 (col. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 + col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Cost of Services								
Part B								
Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00		
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	7,673	6,341		1,335,869	1,103,968		1.00
2.00	Physical Therapy	2,818	1,606		484,386	276,055		2.00
3.00	Occupational Therapy	942	544		162,373	93,769		3.00
4.00	Speech Pathology	202	98		58,045	28,160		4.00
5.00	Medical Social Services	135	113		50,869	42,580		5.00
6.00	Home Health Aide	1,327	2,040		79,846	122,747		6.00
7.00	Total (sum of lines 1-6)	13,097	10,742		2,171,388	1,667,279		7.00
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2012 To 06/30/2013	Worksheet H-3 Part I Date/Time Prepared: 11/22/2013 2:52 pm
				Title XVIII	Home Health Agency I	PPS
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs		0		0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 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	2,439,837				1.00
2.00	Physical Therapy	760,441				2.00
3.00	Occupational Therapy	256,142				3.00
4.00	Speech Pathology	86,205				4.00
5.00	Medical Social Services	93,449				5.00
6.00	Home Health Aide	202,593				6.00
7.00	Total (sum of lines 1-6)	3,838,667				7.00
Cost Center Description						
		12.00				
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140189

Period:

Worksheet H-3

HHA CCN: 147594

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

Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.370920	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.390276	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.412271	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.237754	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.211135	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2012 To 06/30/2013	Worksheet H-4 Part I-II Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	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	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		1,895,916	1,427,872
12.00	Total PPS Reimbursement - Full Episodes with Outliers		37,831	45,208
13.00	Total PPS Reimbursement - LUPA Episodes		18,937	27,506
14.00	Total PPS Reimbursement - PEP Episodes		22,027	19,772
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		10,389	16,709
16.00	Total PPS Outlier Reimbursement - PEP Episodes		113	576
17.00	Total Other Payments		-10,315	-6,788
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		1,974,898	1,530,855
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		1,974,898	1,530,855
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		1,974,898	1,530,855
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		1,974,898	1,530,855
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		1,974,898	1,530,855
32.00	Interim payments (see instructions)		1,974,899	1,530,855
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		-1	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 140189
HHA CCN: 147594

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

Worksheet H-5
Date/Time Prepared:
11/22/2013 2:52 pm
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					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		1,974,899		1,530,855	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)		1,974,899		1,530,855	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		1,974,898		1,530,855	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period:

Worksheet K

Hospice CCN: 141599

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

Date/Time Prepared:
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		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	181,580	0	0	0	694,831	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	1,015,826	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,197,406	0	0	0	694,831	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K

Hospice CCN: 141599

To 06/30/2013

Date/Time Prepared: 11/22/2013 2:52 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	876,411	0	876,411	0	876,411	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	1,015,826	0	1,015,826	0	1,015,826	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,892,237	0	1,892,237	0	1,892,237	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-1

Hospice CCN: 141599

To 06/30/2013

Date/Time Prepared: 11/22/2013 2:52 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	96,169	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	157,172	0	747,239	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	96,169	157,172	0	747,239	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-1

Hospice CCN: 141599

To 06/30/2013

Date/Time Prepared: 11/22/2013 2:52 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	85,411	181,580	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		111,415	0	1,015,826	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	111,415	85,411	1,197,406	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189
 Hospice CCN: 141599

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 11/22/2013 2:52 pm

		Hospice I				
		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT		
		0	1.00	2.00	3.00	4.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0			1.00
2.00	Capital Related Costs-Movable Equip.	0		0		2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	876,411	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	1,015,826	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,892,237	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-4

Hospice CCN: 141599

To 06/30/2013

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

		Hospice I			
	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	876,411	876,411	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	1,015,826	876,411	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
VISITING SERVICES					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	17.00
18.00	Counseling - Other	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	32.00
33.00	Chemotherapy	0	0	0	33.00
34.00	Other	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	36.00
37.00	Fundraising	0	0	0	37.00
38.00	Other Program Costs	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	1,892,237	1,892,237	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-4

Hospice CCN: 141599

To 06/30/2013

Part II
Date/Time Prepared:
11/22/2013 2:52 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-4
Part II
Date/Time Prepared:
11/22/2013 2:52 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-876,411	1,015,826	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	1,015,826	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		876,411	39.00
40.00	Unit Cost Multiplier		0.862757	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-5

Hospice CCN: 141599

To 06/30/2013

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		1.00	2.00	4.00			
1.00 Administrative and General	0	10,579	0	248,997	259,576	1.00	
2.00 Inpatient - General Care	1,892,237	0	0	0	1,892,237	2.00	
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00 Physician Services	0	0	0	0	0	4.00	
5.00 Nursing Care	0	0	0	0	0	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	0	0	0	0	0	7.00	
8.00 Occupational Therapy	0	0	0	0	0	8.00	
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	0	0	0	0	10.00	
11.00 Spiritual Counseling	0	0	0	0	0	11.00	
12.00 Dietary Counseling	0	0	0	0	0	12.00	
13.00 Counseling - Other	0	0	0	0	0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00 Analgesics	0	0	0	0	0	18.00	
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00 Other - Specify	0	0	0	0	0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00 Patient Transportation	0	0	0	0	0	22.00	
23.00 Imaging Services	0	0	0	0	0	23.00	
24.00 Labs and Diagnostics	0	0	0	0	0	24.00	
25.00 Medical Supplies	0	0	0	0	0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00 Radiation Therapy	0	0	0	0	0	27.00	
28.00 Chemotherapy	0	0	0	0	0	28.00	
29.00 Other	0	0	0	0	0	29.00	
30.00 Bereavement Program Costs	0	0	0	0	0	30.00	
31.00 Volunteer Program Costs	0	0	0	0	0	31.00	
32.00 Fundraising	0	0	0	0	0	32.00	
33.00 Other Program Costs	0	0	0	0	0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	1,892,237	10,579	0	248,997	2,151,813	34.00	
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period:

Worksheet K-5

Hospice CCN: 141599

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

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	48,522	38,428	0	21,366	0	1.00
2.00	Inpatient - General Care	353,712	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	402,234	38,428	0	21,366	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-5

Hospice CCN: 141599

To 06/30/2013

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	5,344	0	0	0	37,250	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	5,344	0	0	0	37,250	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period:

Worksheet K-5

Hospice CCN: 141599

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

Part I
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Hospice I					
		Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	410,486					1.00
2.00	Inpatient - General Care	2,245,949	0	2,245,949	410,486	2,656,435	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,656,435	0	2,656,435		2,656,435	34.00
35.00	Unit Cost Multiplier (see instructions)				0.182767		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
1.00	Administrative and General	10,579	0	248,997	0	259,576	1.00
2.00	Inpatient - General Care	0	0	0	0	1,892,237	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	10,579	0	248,997		2,151,813	34.00
35.00	Total cost to be allocated	10,579	0	248,997		402,234	35.00
36.00	Unit Cost Multiplier (see instructions)	1.000000	0.000000	1.000000		0.186928	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189

Period:

Worksheet K-5

Hospice CCN: 141599

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

Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	38,428	0	11,904	0	5,344	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	38,428	0	11,904	0	5,344	34.00
35.00	Total cost to be allocated	38,428	0	21,366	0	5,344	35.00
36.00	Unit Cost Multiplier (see instructions)	1.000000	0.000000	1.794859	0.000000	1.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part II
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description	Hospice I					
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY		
	(DIRECT NURSING HRS)	(COSTED REQUIS.)		(GROSS CHARGES)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	0	37,250		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		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/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	37,250		34.00
35.00 Total cost to be allocated	0	0	0	37,250		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	1.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-5

Hospice CCN: 141599

To 06/30/2013

Part III
Date/Time Prepared:
11/22/2013 2:52 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.370920	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.390276	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.412271	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.211135	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.261888	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.237754	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.240653	0	0 9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	3.579246	0	0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140189

Period: From 07/01/2012

Worksheet K-6

Hospice CCN: 141599

To 06/30/2013

Date/Time Prepared: 11/22/2013 2:52 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,656,435	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				22,047	2.00
3.00	Average cost per diem (line 1 divided by line 2)				120.49	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	19,050				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,295,335				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		741			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		89,283			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	9,103				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,096,820				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		343			10.00
11.00	Aggregate NF cost (line 3 times line 10)		41,328			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			2,256		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			271,825		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet L Parts I-III Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,379,558	1.00
2.00	Capital DRG outlier payments		22,771	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		53.48	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,402,329	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/22/2013 2:52 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	125,221	8,229	133,450	0	133,450	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	99,739	7,052	106,791	0	106,791	9.00
10.00	Subtotal (sum of lines 1-9)	224,960	15,281	240,241	0	240,241	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	16,386	16,386	0	16,386	15.00
16.00	Transportation (Health Care Staff)	0	860	860	0	860	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	10,007	10,007	0	10,007	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,253	27,253	0	27,253	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	224,960	42,534	267,494	0	267,494	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	48,537	48,537	0	48,537	29.00
30.00	Administrative Costs	40,892	4,420	45,312	0	45,312	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,892	52,957	93,849	0	93,849	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	265,852	95,491	361,343	0	361,343	32.00

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

Provider CCN: 140189

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

Worksheet M-1

Component CCN: 143978

Date/Time Prepared:
11/22/2013 2:52 pm

Rural Health
Clinic (RHC) I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	133,450	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	106,791	9.00
10.00	Subtotal (sum of lines 1-9)	0	240,241	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	16,386	15.00
16.00	Transportation (Health Care Staff)	0	860	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	10,007	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	27,253	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	267,494	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	48,537	29.00
30.00	Administrative Costs	0	45,312	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,849	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	361,343	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/22/2013 2:52 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassified	Cost Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	222,261	25,760	248,021	0	248,021	1.00
2.00	Physician Assistant	89,743	8,292	98,035	0	98,035	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	99,080	6,824	105,904	0	105,904	9.00
10.00	Subtotal (sum of lines 1-9)	411,084	40,876	451,960	0	451,960	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	22,714	22,714	0	22,714	15.00
16.00	Transportation (Health Care Staff)	0	2,008	2,008	0	2,008	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	23,379	23,379	0	23,379	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	48,101	48,101	0	48,101	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	411,084	88,977	500,061	0	500,061	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	52,081	52,081	0	52,081	29.00
30.00	Administrative Costs	80,160	10,318	90,478	0	90,478	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	80,160	62,399	142,559	0	142,559	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	491,244	151,376	642,620	0	642,620	32.00

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

Provider CCN: 140189

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

Worksheet M-1

Component CCN: 143998

Date/Time Prepared:
11/22/2013 2:52 pm

Rural Health
Clinic (RHC) II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	248,021	1.00
2.00	Physician Assistant	0	98,035	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	105,904	9.00
10.00	Subtotal (sum of lines 1-9)	0	451,960	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	22,714	15.00
16.00	Transportation (Health Care Staff)	0	2,008	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	23,379	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	48,101	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	500,061	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	52,081	29.00
30.00	Administrative Costs	0	90,478	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	142,559	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	642,620	32.00

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

Provider CCN: 140189
Component CCN: 143435

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

Worksheet M-1
Date/Time Prepared:
11/22/2013 2:52 pm

				Rural Health Clinic (RHC) III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
						Reclassified	Reclassified
						Balance	Balance
						(col. 3 + col. 4)	(col. 3 + col. 4)
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	225,313	13,762	239,075	0	239,075	1.00
2.00	Physician Assistant	271,179	9,647	280,826	0	280,826	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	120,317	8,075	128,392	0	128,392	9.00
10.00	Subtotal (sum of lines 1-9)	616,809	31,484	648,293	0	648,293	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	18,633	18,633	0	18,633	15.00
16.00	Transportation (Health Care Staff)	0	2,012	2,012	0	2,012	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	23,379	23,379	0	23,379	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	44,024	44,024	0	44,024	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	616,809	75,508	692,317	0	692,317	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	39,787	39,787	0	39,787	29.00
30.00	Administrative Costs	72,551	9,463	82,014	0	82,014	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,551	49,250	121,801	0	121,801	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	689,360	124,758	814,118	0	814,118	32.00

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

Provider CCN: 140189

Period:

Worksheet M-1

Component CCN: 143435

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

Date/Time Prepared:
11/22/2013 2:52 pm

Rural Health
Clinic (RHC) III

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	239,075	1.00
2.00	Physician Assistant	0	280,826	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	128,392	9.00
10.00	Subtotal (sum of lines 1-9)	0	648,293	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	18,633	15.00
16.00	Transportation (Health Care Staff)	0	2,012	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	23,379	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	44,024	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	692,317	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	39,787	29.00
30.00	Administrative Costs	0	82,014	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	121,801	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	814,118	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2012	Worksheet M-2
		Component CCN: 143978	To 06/30/2013	Date/Time Prepared: 11/22/2013 2:52 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	0	0	1.00
2.00	Physician Assistant	0.70	3,608	2,100	1,470	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	0.70	3,608		1,470	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.70	3,608			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)		267,494
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		267,494
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)		93,849
15.00	Parent provider overhead allocated to facility (see instructions)		500,600
16.00	Total overhead (sum of lines 14 and 15)		594,449
17.00	Allowable GME overhead (see instructions)		0
18.00	Subtract line 17 from line 16		594,449
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		594,449
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		861,943

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-2		
		Component CCN: 143998		Date/Time Prepared: 11/22/2013 2:52 pm		
			Rural Health Clinic (RHC) II	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	1,768	2,100	2,100	1.00
2.00	Physician Assistant	1.00	1,816	2,100	2,100	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	2.00	3,584		4,200	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.00	3,584		4,200	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				500,061	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				500,061	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				142,559	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				420,101	15.00
16.00	Total overhead (sum of lines 14 and 15)				562,660	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				562,660	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				562,660	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,062,721	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES			Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-2	
			Component CCN: 143435		Date/Time Prepared: 11/22/2013 2:52 pm	
				Rural Health Clinic (RHC) III	Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	1,715	2,100	2,100	1.00
2.00	Physician Assistant	1.25	4,635	2,100	2,625	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	2.25	6,350		4,725	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.25	6,350			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				692,317	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				692,317	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				121,801	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				403,937	15.00
16.00	Total overhead (sum of lines 14 and 15)				525,738	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				525,738	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				525,738	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,218,055	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3
		Component CCN: 143978		Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		861,943	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,622	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		852,321	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,608	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,608	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		236.23	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	431	463	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	33,851	36,656	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		70,507	16.00
16.01	Total program charges (see instructions)(from contractor's records)		100,185	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		43,462	16.04
16.05	Total program cost (see instructions)		43,462	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,180	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,801	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		43,462	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		156	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		43,618	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		43,618	26.00
27.00	Interim payments		42,739	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		879	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3
		Component CCN: 143998		Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,062,721	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,254	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,056,467	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,200	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,200	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		251.54	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	344	413	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	27,018	32,697	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		59,715	16.00
16.01	Total program charges (see instructions)(from contractor's records)		106,282	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		39,577	16.04
16.05	Total program cost (see instructions)		39,577	16.05
17.00	Primary payer amounts		206	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,244	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,208	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		39,371	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		104	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		39,475	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		39,475	26.00
27.00	Interim payments		38,506	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		969	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3
		Component CCN: 143435		Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,218,055	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		5,388	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,212,667	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,350	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,350	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		190.97	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	78.54	79.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	767	817	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	60,240	64,682	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		124,922	16.00
16.01	Total program charges (see instructions)(from contractor's records)		228,599	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		83,230	16.04
16.05	Total program cost (see instructions)		83,230	16.05
17.00	Primary payer amounts		419	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,885	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		41,543	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		82,811	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		43	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,854	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		82,854	26.00
27.00	Interim payments		80,950	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,904	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2012 To 06/30/2013	Worksheet M-4 Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	240,241	240,241	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,320	1,666	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,320	1,666	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	267,494	267,494	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	594,449	594,449	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004935	0.006228	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,934	3,702	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,254	5,368	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	24	138	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	177.25	38.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	156	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		9,622	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		156	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2012 To 06/30/2013	Worksheet M-4 Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	451,960	451,960	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	550	2,393	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	550	2,393	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	500,061	500,061	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	562,660	562,660	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001100	0.004785	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	619	2,692	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,169	5,085	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	196	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	116.90	25.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	104	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,254	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		104	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2012 To 06/30/2013	Worksheet M-4 Date/Time Prepared: 11/22/2013 2:52 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	648,293	648,293	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	550	2,513	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	550	2,513	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	692,317	692,317	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	525,738	525,738	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000794	0.003630	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	417	1,908	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	967	4,421	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	206	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	96.70	21.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	43	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		5,388	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		43	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-5
	Component CCN: 143978		Date/Time Prepared: 11/22/2013 2:52 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		42,739	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		42,739	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		879	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		43,618	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2012 To 06/30/2013	Worksheet M-5 Date/Time Prepared: 11/22/2013 2:52 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		38,506	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		38,506	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		969	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		39,475	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2012 To 06/30/2013	Worksheet M-5
	Component CCN: 143435		Date/Time Prepared: 11/22/2013 2:52 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		80,950	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		80,950	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,904	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,854	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00