

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: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/19/2014 9:33 am
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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: 11/19/2014	Time: 9:33 am
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 FAIRFIELD MEMORIAL HOSPITAL (141311) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	398,901	-345,620	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	70,354	0	0	10.00
200.00 Total	0	398,901	-275,266	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 9:32 am
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 303 NW 11TH STREET	3.00 PO Box:	4.00 State: IL	5.00 Zip Code: 62837	6.00 County: WAYNE
2.00 City: FAIRFIELD					

	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	FAIRFIELD MEMORIAL HOSPITAL	141311	14999	1	04/01/2001	N	O	O	3.00
4.00 Subprovider - IPF									4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF									7.00
8.00 Swing Beds - NF									8.00
9.00 Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	14999		03/26/1985	N	P	N	9.00
10.00 Hospital-Based NF									10.00
11.00 Hospital-Based OLTC									11.00
12.00 Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	14999		05/01/1995	N	P	N	12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital-Based Hospice									14.00
15.00 Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	14999		03/13/2009	N	O	N	15.00
16.00 Hospital-Based Health Clinic - FQHC									16.00
17.00 Hospital-Based (CMHC) I									17.00
18.00 Renal Dialysis									18.00
19.00 Other									19.00

		From:	To:	
		1.00	2.00	
20.00 Cost Reporting Period (mm/dd/yyyy)		07/01/2013	06/30/2014	20.00
21.00 Type of Control (see instructions)		2		21.00

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

	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.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39.00	
		V	XVII	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	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0
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	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N
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
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.					
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y
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
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
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
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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.	0			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

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		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
		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 1.00	Part B 2.00	Title V 3.00	Title XIX 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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
		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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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
		1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y			167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0			168.00		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00			169.00		
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013		06/30/2014			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 9:32 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	10/31/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/23/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-2
Part II
Date/Time Prepared:
11/19/2014 9:32 am

	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CH		FERRI ELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLI ANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832		RFERRI ELL@ALLI ANTMANAGEMENT.COM	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)	10/23/2014	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.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 9:32 am

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)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	47,520.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	47,520.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	11,352.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	58,872.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	30	10,950		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		55				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 9:32 am

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)(see instructions for col. 2 for the portion of LDP room available beds)	1,681	201	1,980			1.00
2.00 HMO and other (see instructions)	10	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			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,681	201	1,980			7.00
8.00 INTENSIVE CARE UNIT	154	16	473			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		0	0			13.00
14.00 Total (see instructions)	1,835	217	2,453	0.00	165.52	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,850	0	6,908	0.00	18.59	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	2,707	0	3,114	0.00	4.69	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	6,749	0	18,481	0.00	25.63	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	214.43	27.00
28.00 Observation Bed Days		0	926			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	562	75	769	1.00
2.00 HMO and other (see instructions)			3	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	562	75	769	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 11/19/2014 9:32 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			128,376 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			0 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)			1,202,065 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			49,916 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			188,161 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			716,442 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			3,059 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			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			2,288,019 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141311 Component CCN: 147612		Period: From 07/01/2013 To 06/30/2014		Worksheet S-4 Date/Time Prepared: 11/19/2014 9:32 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	WAYNE				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	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	135.00	0.00	35.00	170.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)	0.00			0.00	0.00	4.00
5.00	Other Administrative Personnel	0.00			0.00	0.00	5.00
6.00	Direct Nursing Service	0.00			0.00	0.00	6.00
7.00	Nursing Supervisor	0.00			0.00	0.00	7.00
8.00	Physical Therapy Service	0.00			0.00	0.00	8.00
9.00	Physical Therapy Supervisor	0.00			0.00	0.00	9.00
10.00	Occupational Therapy Service	0.00			0.00	0.00	10.00
11.00	Occupational Therapy Supervisor	0.00			0.00	0.00	11.00
12.00	Speech Pathology Service	0.00			0.00	0.00	12.00
13.00	Speech Pathology Supervisor	0.00			0.00	0.00	13.00
14.00	Medical Social Service	0.00			0.00	0.00	14.00
15.00	Medical Social Service Supervisor	0.00			0.00	0.00	15.00
16.00	Home Health Aide	0.00			0.00	0.00	16.00
17.00	Home Health Aide Supervisor	0.00			0.00	0.00	17.00
18.00	Other (specify)	0.00			0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	14999					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,473	199	76	7	1,755	21.00
22.00	Skilled Nursing Visit Charges	141,351	21,340	5,500	660	168,851	22.00
23.00	Physical Therapy Visits	768	0	16	0	784	23.00
24.00	Physical Therapy Visit Charges	80,850	0	1,430	0	82,280	24.00
25.00	Occupational Therapy Visits	136	0	1	0	137	25.00
26.00	Occupational Therapy Visit Charges	14,740	0	110	0	14,850	26.00
27.00	Speech Pathology Visits	30	0	1	0	31	27.00
28.00	Speech Pathology Visit Charges	3,220	0	115	0	3,335	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,407	199	94	7	2,707	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	240,161	21,340	7,155	660	269,316	35.00
36.00	Total Number of Episodes (standard/non outlier)	154		23	1	178	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	39,605	2,326	1,549	55	43,535	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-7

Date/Time Prepared:
11/19/2014 9:32 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	22	0	22 3.00
4.00		RUL	14	0	14 4.00
5.00		RVX	14	0	14 5.00
6.00		RVL	31	0	31 6.00
7.00		RHX	39	0	39 7.00
8.00		RHL	36	0	36 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	26	0	26 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	44	0	44 12.00
13.00		RUB	34	0	34 13.00
14.00		RUA	73	0	73 14.00
15.00		RVC	172	0	172 15.00
16.00		RVB	143	0	143 16.00
17.00		RVA	286	0	286 17.00
18.00		RHC	109	0	109 18.00
19.00		RHB	214	0	214 19.00
20.00		RHA	206	0	206 20.00
21.00		RMC	59	0	59 21.00
22.00		RMB	12	0	12 22.00
23.00		RMA	57	0	57 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	14	0	14 28.00
29.00		HE2	9	0	9 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	27	0	27 31.00
32.00		HD1	9	0	9 32.00
33.00		HC2	14	0	14 33.00
34.00		HC1	7	0	7 34.00
35.00		HB2	7	0	7 35.00
36.00		HB1	8	0	8 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	3	0	3 41.00
42.00		LC1	9	0	9 42.00
43.00		LB2	9	0	9 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	28	0	28 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	12	0	12 48.00
49.00		CC2	28	0	28 49.00
50.00		CC1	17	0	17 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	35	0	35 52.00
53.00		CA2	8	0	8 53.00
54.00		CA1	2	0	2 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	4	0	4 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-7

Date/Time Prepared:
11/19/2014 9:32 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,850	0	1,850	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).
 14999 14999 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	989,906			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2013 To 06/30/2014	Worksheet S-8 Date/Time Prepared: 11/19/2014 9:32 am	
			Rural Health Clinic (RHC) I	Cost	
1.00					
Clinic Address and Identification					
1.00	Street	303 NW 11TH STREET		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	FAIRFIELD	IL	62837 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic			09:00	05:00 09:00 11.00
1.00 2.00					
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, 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			Total Visits	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0	0 0 0 15.00
			County		
			4.00		
2.00	City, State, Zip Code, County			WAYNE 2.00	
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1) Clinic			05:00	09:00 05:00 09:00 05:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2013 To 06/30/2014	Worksheet S-8 Date/Time Prepared: 11/19/2014 9:32 am
		Rural Health Clinic (RHC) I	Cost

	Friday		Saturday									
	from	to	from	to								
	11.00	11.00	12.00	13.00			14.00					
11.00	Facility hours of operations (1) Clinic					09:00	05:00					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-10

Date/Time Prepared:
11/19/2014 9:32 am

		1.00			
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.362514			1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	2,012,522			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,764,231			5.00
6.00	Medicaid charges	10,582,985			6.00
7.00	Medicaid cost (line 1 times line 6)	3,836,480			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)	59,727			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)	59,727			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	803,511	57,127	860,638	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	291,284	20,709	311,993	21.00
22.00	Partial payment by patients approved for charity care	695	427	1,122	22.00
23.00	Cost of charity care (line 21 minus line 22)	290,589	20,282	310,871	23.00
		1.00			
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0			25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,718,633			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	717,499			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,001,134			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	725,439			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,036,310			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,096,037			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		1,288,346	1,288,346	273,341	1,561,687	1.00
2.00	00200		0	0	349,797	349,797	2.00
4.00	00400	95,298	2,299,091	2,394,389	0	2,394,389	4.00
5.00	00500	976,874	2,363,460	3,340,334	-6,711	3,333,623	5.00
6.00	00600	288,710	328,263	616,973	-540	616,433	6.00
7.00	00700	0	577,625	577,625	0	577,625	7.00
8.00	00800	0	441,338	441,338	0	441,338	8.00
9.00	00900	320,532	159,159	479,691	0	479,691	9.00
10.00	01000	53,917	753,129	807,046	-354,993	452,053	10.00
11.00	01100	0	0	0	354,993	354,993	11.00
13.00	01300	216,711	21,701	238,412	0	238,412	13.00
16.00	01600	262,001	191,251	453,252	0	453,252	16.00
17.00	01700	89,853	6,856	96,709	0	96,709	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,217,686	59,415	1,277,101	-169	1,276,932	30.00
31.00	03100	198,296	5,570	203,866	0	203,866	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	611,627	35,668	647,295	-1,988	645,307	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,011,331	280,029	1,291,360	-71,434	1,219,926	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	415,005	1,104,779	1,519,784	-145,062	1,374,722	54.00
60.00	06000	776,962	1,124,382	1,901,344	-109,185	1,792,159	60.00
65.00	06500	160,083	138,621	298,704	-103,862	194,842	65.00
66.00	06600	622,645	16,262	638,907	0	638,907	66.00
69.00	06900	0	0	0	89,561	89,561	69.00
71.00	07100	47,137	741,879	789,016	-59,419	729,597	71.00
72.00	07200	0	0	0	59,419	59,419	72.00
73.00	07300	203,705	937,737	1,141,442	0	1,141,442	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	2,018,796	289,734	2,308,530	-407	2,308,123	88.00
90.00	09000	205,969	125,815	331,784	0	331,784	90.00
90.01	09001	25,822	189,068	214,890	0	214,890	90.01
91.00	09100	573,415	1,697,837	2,271,252	0	2,271,252	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	239,547	60,102	299,649	0	299,649	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		384,086	384,086	-273,341	110,745	113.00
118.00		10,631,922	15,621,203	26,253,125	0	26,253,125	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		10,631,922	15,621,203	26,253,125	0	26,253,125	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-300,912	1,260,775	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	349,797	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,394,389	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-969,761	2,363,862	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	616,433	6.00
7.00	00700	OPERATION OF PLANT	0	577,625	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	441,338	8.00
9.00	00900	HOUSEKEEPING	0	479,691	9.00
10.00	01000	DIETARY	0	452,053	10.00
11.00	01100	CAFETERIA	-106,276	248,717	11.00
13.00	01300	NURSING ADMINISTRATION	0	238,412	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,494	445,758	16.00
17.00	01700	SOCIAL SERVICE	0	96,709	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-124,036	1,152,896	30.00
31.00	03100	INTENSIVE CARE UNIT	0	203,866	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	645,307	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-490,400	729,526	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	972	1,375,694	54.00
60.00	06000	LABORATORY	0	1,792,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	194,842	65.00
66.00	06600	PHYSICAL THERAPY	0	638,907	66.00
69.00	06900	ELECTROCARDIOLOGY	-49,833	39,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	729,597	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	59,419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,141,442	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,308,123	88.00
90.00	09000	CLINIC	0	331,784	90.00
90.01	09001	WOUND CARE	0	214,890	90.01
91.00	09100	EMERGENCY	-1,141,327	1,129,925	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	299,649	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-110,745	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,299,812	22,953,313	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	DR. OFFICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,299,812	22,953,313	200.00

RECLASSIFICATIONS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
11/19/2014 9:32 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	23,716	331,277	1.00
	TOTALS		23,716	331,277	
C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	39,728	49,833	1.00
	TOTALS		39,728	49,833	
D - RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	349,797	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
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
22.00		0.00	0	0	22.00
	TOTALS		0	349,797	
E - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	273,341	1.00
	TOTALS		0	273,341	
F - IMPLANTABLE DEVICE					
1.00	IMP. DEV CHARGED TO PATIENT	72.00	0	59,419	1.00
	TOTALS		0	59,419	
500.00	Grand Total: Increases		63,444	1,063,667	500.00

RECLASSIFICATIONS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
11/19/2014 9:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	23,716	331,277	0		1.00
	TOTALS		23,716	331,277			
C - EKG							
1.00	RESPIRATORY THERAPY	65.00	39,728	49,833	0		1.00
	TOTALS		39,728	49,833			
D - RENTAL							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	6,711	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	540	0		3.00
11.00	ADULTS & PEDIATRICS	30.00	0	169	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,988	0		12.00
13.00	OPERATING ROOM	50.00	0	71,434	0		13.00
14.00	RADIOLOGY - DIAGNOSTIC	54.00	0	145,062	0		14.00
15.00	LABORATORY	60.00	0	109,185	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	14,301	0		16.00
22.00	RURAL HEALTH CLINIC	88.00	0	407	0		22.00
	TOTALS		0	349,797			
E - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	273,341	9		1.00
	TOTALS		0	273,341			
F - IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	59,419	0		1.00
	TOTALS		0	59,419			
500.00	Grand Total: Decreases		63,444	1,063,667			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
11/19/2014 9:32 am

	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	421,395	0	0	0	1.00
2.00	Land Improvements	640,428	0	0	0	2.00
3.00	Buildings and Fixtures	22,977,074	173,183	0	173,183	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,229,238	7,001	0	7,001	5.00
6.00	Movable Equipment	9,104,296	1,360,230	0	1,360,230	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,372,431	1,540,414	0	1,540,414	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,372,431	1,540,414	0	1,540,414	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	421,395	0			1.00
2.00	Land Improvements	640,428	0			2.00
3.00	Buildings and Fixtures	23,150,257	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	1,236,239	0			5.00
6.00	Movable Equipment	10,464,526	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	35,912,845	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	35,912,845	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,288,346	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,288,346	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,288,346				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,288,346				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,288,346	0	1,288,346	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,288,346	0	1,288,346	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,260,775	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	349,797	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,610,572	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,260,775	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	349,797	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,610,572	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8

Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst.	A-7 Ref.
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00 Investment income - other (chapter 2)	B	-110,745	INTEREST EXPENSE	113.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,902	ADMINISTRATIVE & GENERAL	5.00		0 7.00
8.00 Television and radio service (chapter 21)		0		0.00		0 8.00
9.00 Parking lot (chapter 21)		0		0.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,805,596				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-1	ADMINISTRATIVE & GENERAL	5.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	972				0 12.00
13.00 Laundry and linen service		0		0.00		0 13.00
14.00 Cafeteria-employees and guests	B	-106,276	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	-7,494	MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00 Vending machines		0		0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP 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*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-53,106	CAP REL COSTS-BLDG & FIXT	1.00		9 32.00
33.00 OFFICE SPACE RENTAL	B	-85,397	CAP REL COSTS-BLDG & FIXT	1.00		9 33.00
33.01 RINARD & WEBER CLINIC	A	-12,409	CAP REL COSTS-BLDG & FIXT	1.00		9 33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8

Date/Time Prepared:
11/19/2014 9:32 am

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		
33.02 RECRUITING	A	-122,570	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 ADVERTISING	A	-97,709	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 OTHER REVENUE	B	-173,260	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 WAYFAIR RENTAL	B	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06 PROVIDER TAX EXPENSE	A	-573,319	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07		0		0.00	0	33.07
33.08		0		0.00	0	33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,299,812				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
11/19/2014 9:32 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY - DIAGNOSTIC	223,469	222,497	1.00
2.00	0.00	MRI	0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	223,469	222,497	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	DSSI	15.00	DSSI	15.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
11/19/2014 9:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	972	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	972			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MRI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-2

Date/Time Prepared:
11/19/2014 9:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	124,036	124,036	0	0	0	1.00
2.00	50.00	OPERATING ROOM	490,400	490,400	0	0	0	2.00
3.00	60.00	LABORATORY	26,000	0	26,000	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	49,833	49,833	0	0	0	4.00
5.00	91.00	EMERGENCY	1,571,643	1,141,327	430,316	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,261,912	1,805,596	456,316			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	124,036		1.00
2.00	50.00	OPERATING ROOM	0	0	0	490,400		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	49,833		4.00
5.00	91.00	EMERGENCY	0	0	0	1,141,327		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,805,596		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,260,775	1,260,775			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	349,797		349,797		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,394,389	0	0	2,394,389	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,363,862	262,095	72,718	221,989	2,920,664 5.00
6.00 00600	MAINTENANCE & REPAIRS	616,433	35,757	9,921	65,608	727,719 6.00
7.00 00700	OPERATION OF PLANT	577,625	23,371	6,484	0	607,480 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	441,338	16,149	4,480	0	461,967 8.00
9.00 00900	HOUSEKEEPING	479,691	2,235	620	72,839	555,385 9.00
10.00 01000	DIETARY	452,053	5,871	1,629	6,863	466,416 10.00
11.00 01100	CAFETERIA	248,717	6,250	1,734	5,389	262,090 11.00
13.00 01300	NURSING ADMINISTRATION	238,412	1,616	448	49,246	289,722 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	445,758	13,965	3,874	59,538	523,135 16.00
17.00 01700	SOCIAL SERVICE	96,709	2,020	560	20,419	119,708 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,152,896	184,330	51,142	276,712	1,665,080 30.00
31.00 03100	INTENSIVE CARE UNIT	203,866	16,831	4,670	45,062	270,429 31.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	645,307	107,992	29,962	138,989	922,250 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	729,526	81,969	22,742	229,819	1,064,056 50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0 52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	1,375,694	57,803	16,037	94,307	1,543,841 54.00
60.00 06000	LABORATORY	1,792,159	28,636	7,945	176,560	2,005,300 60.00
65.00 06500	RESPIRATORY THERAPY	194,842	21,262	5,899	27,350	249,353 65.00
66.00 06600	PHYSICAL THERAPY	638,907	45,568	12,643	141,492	838,610 66.00
69.00 06900	ELECTROCARDIOLOGY	39,728	0	0	9,028	48,756 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	729,597	22,424	6,221	10,712	768,954 71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	59,419	0	0	0	59,419 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,141,442	34,444	9,556	46,291	1,231,733 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	2,308,123	187,322	51,972	458,762	3,006,179 88.00
90.00 09000	CLINIC	331,784	21,906	6,078	46,805	406,573 90.00
90.01 09001	WOUND CARE	214,890	27,399	7,602	5,868	255,759 90.01
91.00 09100	EMERGENCY	1,129,925	29,318	8,134	130,305	1,297,682 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	299,649	24,242	6,726	54,436	385,053 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,953,313	1,260,775	349,797	2,394,389	22,953,313 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	0 194.00
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)	22,953,313	1,260,775	349,797	2,394,389	22,953,313 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	2,920,664				5.00	
6.00	00600	MAINTENANCE & REPAIRS	106,098	833,817			6.00	
7.00	00700	OPERATION OF PLANT	88,568	20,238	716,286		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	67,352	13,984	12,311	555,614	8.00	
9.00	00900	HOUSEKEEPING	80,972	1,935	1,704	65,716	705,712	9.00
10.00	01000	DIETARY	68,001	5,084	4,476	0	4,498	10.00
11.00	01100	CAFETERIA	38,211	5,412	4,765	0	4,788	11.00
13.00	01300	NURSING ADMINISTRATION	42,240	1,399	1,232	0	1,238	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,270	12,092	10,646	0	10,698	16.00
17.00	01700	SOCIAL SERVICE	17,453	1,749	1,540	0	1,548	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	242,760	159,615	140,527	116,352	141,216	30.00
31.00	03100	INTENSIVE CARE UNIT	39,427	14,574	12,831	4,756	12,894	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	134,459	93,512	82,330	141,698	82,733	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	155,134	70,979	62,491	67,094	62,797	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	225,084	50,053	44,067	33,946	44,283	54.00
60.00	06000	LABORATORY	292,363	24,797	21,831	7,598	21,938	60.00
65.00	06500	RESPIRATORY THERAPY	36,354	18,412	16,210	8,657	16,289	65.00
66.00	06600	PHYSICAL THERAPY	122,265	39,458	34,740	26,985	34,910	66.00
69.00	06900	ELECTROCARDIOLOGY	7,108	0	0	6,221	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,110	19,418	17,095	0	17,179	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	8,663	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,581	29,826	26,259	0	26,388	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	438,292	162,207	142,809	9,715	143,509	88.00
90.00	09000	CLINIC	59,276	18,969	16,701	0	16,783	90.00
90.01	09001	WOUND CARE	37,288	23,725	20,888	0	20,990	90.01
91.00	09100	EMERGENCY	189,196	25,387	22,351	66,876	22,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	56,139	20,992	18,482	0	18,572	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,920,664	833,817	716,286	555,614	705,712	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	DR. OFFICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,920,664	833,817	716,286	555,614	705,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	548,475					10.00
11.00	01100	0	315,266				11.00
13.00	01300	0	5,752	341,583			13.00
16.00	01600	0	15,728	0	648,569		16.00
17.00	01700	0	4,760	0	0	146,758	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	116,008	50,829	123,891	51,503	146,758	30.00
31.00	03100	27,721	6,865	16,733	4,917	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	404,746	35,533	86,612	10,222	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	22,830	55,648	40,456	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	16,566	0	156,172	0	54.00
60.00	06000	0	38,759	0	121,677	0	60.00
65.00	06500	0	5,835	0	34,826	0	65.00
66.00	06600	0	17,729	0	29,153	0	66.00
69.00	06900	0	1,926	0	14,687	0	69.00
71.00	07100	0	3,633	0	41,013	0	71.00
72.00	07200	0	0	0	1,670	0	72.00
73.00	07300	0	6,096	0	55,986	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	49,024	0	32,525	0	88.00
90.00	09000	0	9,098	0	11,075	0	90.00
90.01	09001	0	221	0	7,601	0	90.01
91.00	09100	0	24,082	58,699	35,086	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		548,475	315,266	341,583	648,569	146,758	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		548,475	315,266	341,583	648,569	146,758	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
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
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,954,539	0	2,954,539	30.00
31.00	03100	411,147	0	411,147	31.00
43.00	04300	0	0	0	43.00
44.00	04400	1,994,095	0	1,994,095	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,601,485	0	1,601,485	50.00
52.00	05200	0	0	0	52.00
54.00	05400	2,114,012	0	2,114,012	54.00
60.00	06000	2,534,263	0	2,534,263	60.00
65.00	06500	385,936	0	385,936	65.00
66.00	06600	1,143,850	0	1,143,850	66.00
69.00	06900	78,698	0	78,698	69.00
71.00	07100	979,402	0	979,402	71.00
72.00	07200	69,752	0	69,752	72.00
73.00	07300	1,555,869	0	1,555,869	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	3,984,260	0	3,984,260	88.00
90.00	09000	538,475	0	538,475	90.00
90.01	09001	366,472	0	366,472	90.01
91.00	09100	1,741,820	0	1,741,820	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	499,238	0	499,238	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		22,953,313	0	22,953,313	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		22,953,313	0	22,953,313	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	262,095	72,718	334,813	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	35,757	9,921	45,678	6.00
7.00 00700	OPERATION OF PLANT	0	23,371	6,484	29,855	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,149	4,480	20,629	8.00
9.00 00900	HOUSEKEEPING	0	2,235	620	2,855	9.00
10.00 01000	DIETARY	0	5,871	1,629	7,500	10.00
11.00 01100	CAFETERIA	0	6,250	1,734	7,984	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,616	448	2,064	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	13,965	3,874	17,839	16.00
17.00 01700	SOCIAL SERVICE	0	2,020	560	2,580	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	184,330	51,142	235,472	30.00
31.00 03100	INTENSIVE CARE UNIT	0	16,831	4,670	21,501	31.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	107,992	29,962	137,954	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	81,969	22,742	104,711	50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	57,803	16,037	73,840	54.00
60.00 06000	LABORATORY	0	28,636	7,945	36,581	60.00
65.00 06500	RESPIRATORY THERAPY	0	21,262	5,899	27,161	65.00
66.00 06600	PHYSICAL THERAPY	0	45,568	12,643	58,211	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,424	6,221	28,645	71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	34,444	9,556	44,000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	187,322	51,972	239,294	88.00
90.00 09000	CLINIC	0	21,906	6,078	27,984	90.00
90.01 09001	WOUND CARE	0	27,399	7,602	35,001	90.01
91.00 09100	EMERGENCY	0	29,318	8,134	37,452	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	24,242	6,726	30,968	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,260,775	349,797	1,610,572	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,260,775	349,797	1,610,572	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	334,813					5.00
6.00	00600	12,162	57,840				6.00
7.00	00700	10,153	1,404	41,412			7.00
8.00	00800	7,721	970	712	30,032		8.00
9.00	00900	9,282	134	99	3,552	15,922	9.00
10.00	01000	7,795	353	259	0	101	10.00
11.00	01100	4,380	375	275	0	108	11.00
13.00	01300	4,842	97	71	0	28	13.00
16.00	01600	8,743	839	616	0	241	16.00
17.00	01700	2,001	121	89	0	35	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,828	11,072	8,125	6,289	3,186	30.00
31.00	03100	4,520	1,011	742	257	291	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	15,414	6,487	4,760	7,658	1,867	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,784	4,924	3,613	3,627	1,417	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	25,802	3,472	2,548	1,835	999	54.00
60.00	06000	33,515	1,720	1,262	411	495	60.00
65.00	06500	4,167	1,277	937	468	368	65.00
66.00	06600	14,016	2,737	2,008	1,459	788	66.00
69.00	06900	815	0	0	336	0	69.00
71.00	07100	12,852	1,347	988	0	388	71.00
72.00	07200	993	0	0	0	0	72.00
73.00	07300	20,586	2,069	1,518	0	595	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	50,249	11,252	8,255	525	3,236	88.00
90.00	09000	6,795	1,316	966	0	379	90.00
90.01	09001	4,275	1,646	1,208	0	474	90.01
91.00	09100	21,688	1,761	1,292	3,615	507	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,435	1,456	1,069	0	419	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		334,813	57,840	41,412	30,032	15,922	
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		334,813	57,840	41,412	30,032	15,922	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	16,008					10.00
11.00	01100	0	13,122				11.00
13.00	01300	0	239	7,341			13.00
16.00	01600	0	655	0	28,933		16.00
17.00	01700	0	198	0	0	5,024	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,386	2,116	2,663	2,299	5,024	30.00
31.00	03100	809	286	360	219	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	11,813	1,479	1,861	456	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	950	1,196	1,806	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	690	0	6,952	0	54.00
60.00	06000	0	1,613	0	5,432	0	60.00
65.00	06500	0	243	0	1,555	0	65.00
66.00	06600	0	738	0	1,302	0	66.00
69.00	06900	0	80	0	656	0	69.00
71.00	07100	0	151	0	1,831	0	71.00
72.00	07200	0	0	0	75	0	72.00
73.00	07300	0	254	0	2,499	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	2,040	0	1,452	0	88.00
90.00	09000	0	379	0	494	0	90.00
90.01	09001	0	9	0	339	0	90.01
91.00	09100	0	1,002	1,261	1,566	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		16,008	13,122	7,341	28,933	5,024	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		16,008	13,122	7,341	28,933	5,024	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
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
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	307,460	0	307,460	30.00
31.00	03100	29,996	0	29,996	31.00
43.00	04300	0	0	0	43.00
44.00	04400	189,749	0	189,749	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	140,028	0	140,028	50.00
52.00	05200	0	0	0	52.00
54.00	05400	116,138	0	116,138	54.00
60.00	06000	81,029	0	81,029	60.00
65.00	06500	36,176	0	36,176	65.00
66.00	06600	81,259	0	81,259	66.00
69.00	06900	1,887	0	1,887	69.00
71.00	07100	46,202	0	46,202	71.00
72.00	07200	1,068	0	1,068	72.00
73.00	07300	71,521	0	71,521	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	316,303	0	316,303	88.00
90.00	09000	38,313	0	38,313	90.00
90.01	09001	42,952	0	42,952	90.01
91.00	09100	70,144	0	70,144	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	40,347	0	40,347	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		1,610,572	0	1,610,572	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,610,572	0	1,610,572	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	99,854				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		99,854			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,536,623		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,758	20,758	976,874	-2,920,664	20,032,649
6.00 00600	MAINTENANCE & REPAIRS	2,832	2,832	288,710	0	727,719
7.00 00700	OPERATION OF PLANT	1,851	1,851	0	0	607,480
8.00 00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	461,967
9.00 00900	HOUSEKEEPING	177	177	320,532	0	555,385
10.00 01000	DIETARY	465	465	30,200	0	466,416
11.00 01100	CAFETERIA	495	495	23,716	0	262,090
13.00 01300	NURSING ADMINISTRATION	128	128	216,711	0	289,722
16.00 01600	MEDICAL RECORDS & LIBRARY	1,106	1,106	262,001	0	523,135
17.00 01700	SOCIAL SERVICE	160	160	89,853	0	119,708
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,599	14,599	1,217,686	0	1,665,080
31.00 03100	INTENSIVE CARE UNIT	1,333	1,333	198,296	0	270,429
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	8,553	8,553	611,627	0	922,250
45.00 04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,492	6,492	1,011,331	0	1,064,056
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY - DIAGNOSTIC	4,578	4,578	415,005	0	1,543,841
60.00 06000	LABORATORY	2,268	2,268	776,962	0	2,005,300
65.00 06500	RESPIRATORY THERAPY	1,684	1,684	120,355	0	249,353
66.00 06600	PHYSICAL THERAPY	3,609	3,609	622,645	0	838,610
69.00 06900	ELECTROCARDIOLOGY	0	0	39,728	0	48,756
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	47,137	0	768,954
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	59,419
73.00 07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	203,705	0	1,231,733
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	14,836	14,836	2,018,796	0	3,006,179
90.00 09000	CLINIC	1,735	1,735	205,969	0	406,573
90.01 09001	WOUND CARE	2,170	2,170	25,822	0	255,759
91.00 09100	EMERGENCY	2,322	2,322	573,415	0	1,297,682
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,920	1,920	239,547	0	385,053
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,854	99,854	10,536,623	-2,920,664	20,032,649
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,260,775	349,797	2,394,389		2,920,664
203.00	Unit cost multiplier (Wkst. B, Part I)	12.626184	3.503085	0.227244		0.145795
204.00	Cost to be allocated (per Wkst. B, Part II)			0		334,813
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.016713

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	76,264					6.00
7.00	00700	1,851	74,413				7.00
8.00	00800	1,279	1,279	38,317			8.00
9.00	00900	177	177	4,532	72,957		9.00
10.00	01000	465	465	0	465	33,833	10.00
11.00	01100	495	495	0	495	0	11.00
13.00	01300	128	128	0	128	0	13.00
16.00	01600	1,106	1,106	0	1,106	0	16.00
17.00	01700	160	160	0	160	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,599	14,599	8,024	14,599	7,156	30.00
31.00	03100	1,333	1,333	328	1,333	1,710	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	8,553	8,553	9,772	8,553	24,967	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,492	6,492	4,627	6,492	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	4,578	4,578	2,341	4,578	0	54.00
60.00	06000	2,268	2,268	524	2,268	0	60.00
65.00	06500	1,684	1,684	597	1,684	0	65.00
66.00	06600	3,609	3,609	1,861	3,609	0	66.00
69.00	06900	0	0	429	0	0	69.00
71.00	07100	1,776	1,776	0	1,776	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,728	2,728	0	2,728	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	14,836	14,836	670	14,836	0	88.00
90.00	09000	1,735	1,735	0	1,735	0	90.00
90.01	09001	2,170	2,170	0	2,170	0	90.01
91.00	09100	2,322	2,322	4,612	2,322	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,920	1,920	0	1,920	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		76,264	74,413	38,317	72,957	33,833	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		833,817	716,286	555,614	705,712	548,475	202.00
203.00		10.933297	9.625818	14.500457	9.672985	16.211243	203.00
204.00		57,840	41,412	30,032	15,922	16,008	204.00
205.00		0.758418	0.556516	0.783777	0.218238	0.473148	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	343,008				11.00
13.00	01300	6,258	152,469			13.00
16.00	01600	17,112	0	62,809,560		16.00
17.00	01700	5,179	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	55,300	55,300	4,987,664	100	30.00
31.00	03100	7,469	7,469	476,133	0	31.00
43.00	04300	0	0	0	0	43.00
44.00	04400	38,660	38,660	989,906	0	44.00
45.00	04500	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	24,839	24,839	3,917,843	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	18,024	0	15,124,467	0	54.00
60.00	06000	42,170	0	11,783,535	0	60.00
65.00	06500	6,349	0	3,372,651	0	65.00
66.00	06600	19,289	0	2,823,262	0	66.00
69.00	06900	2,096	0	1,422,364	0	69.00
71.00	07100	3,953	0	3,971,831	0	71.00
72.00	07200	0	0	161,734	0	72.00
73.00	07300	6,632	0	5,421,836	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	53,338	0	3,149,837	0	88.00
90.00	09000	9,899	0	1,072,572	0	90.00
90.01	09001	240	0	736,087	0	90.01
91.00	09100	26,201	26,201	3,397,838	0	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		343,008	152,469	62,809,560	100	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		315,266	341,583	648,569	146,758	202.00
203.00		0.919121	2.240344	0.010326	1,467.580000	203.00
204.00		13,122	7,341	28,933	5,024	204.00
205.00		0.038256	0.048147	0.000461	50.240000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		2,954,539	0	2,954,539	30.00
31.00	03100 INTENSIVE CARE UNIT		411,147	0	411,147	31.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		1,994,095	0	1,994,095	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,601,485	0	1,601,485	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC		2,114,012	0	2,114,012	54.00
60.00	06000 LABORATORY		2,534,263	0	2,534,263	60.00
65.00	06500 RESPIRATORY THERAPY	0	385,936	0	385,936	65.00
66.00	06600 PHYSICAL THERAPY	0	1,143,850	0	1,143,850	66.00
69.00	06900 ELECTROCARDIOLOGY		78,698	0	78,698	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		979,402	0	979,402	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT		69,752	0	69,752	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,555,869	0	1,555,869	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		3,984,260	0	3,984,260	88.00
90.00	09000 CLINIC		538,475	0	538,475	90.00
90.01	09001 WOUND CARE		366,472	0	366,472	90.01
91.00	09100 EMERGENCY		1,741,820	0	1,741,820	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		941,464	0	941,464	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		499,238	0	499,238	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		23,894,777	0	23,894,777	200.00
201.00	Less Observation Beds		941,464		941,464	201.00
202.00	Total (see instructions)		22,953,313	0	22,953,313	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,068,057		4,068,057		30.00
31.00	03100	INTENSIVE CARE UNIT	476,133		476,133		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	989,906		989,906		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	491,490	3,426,353	3,917,843	0.408767	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	935,118	14,189,349	15,124,467	0.139774	54.00
60.00	06000	LABORATORY	1,435,036	10,348,499	11,783,535	0.215068	60.00
65.00	06500	RESPIRATORY THERAPY	613,910	1,750,395	2,364,305	0.163234	65.00
66.00	06600	PHYSICAL THERAPY	1,068,528	1,754,734	2,823,262	0.405152	66.00
69.00	06900	ELECTROCARDIOLOGY	242,398	1,179,966	1,422,364	0.055329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,730,855	3,249,322	4,980,177	0.196660	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	12,838	148,896	161,734	0.431276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,405,384	4,016,452	5,421,836	0.286963	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,149,837	3,149,837		88.00
90.00	09000	CLINIC	0	1,072,572	1,072,572	0.502041	90.00
90.01	09001	WOUND CARE	998	735,089	736,087	0.497865	90.01
91.00	09100	EMERGENCY	82,990	3,314,848	3,397,838	0.512626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	109,614	809,993	919,607	1.023768	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	507,491	507,491		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	13,663,255	49,653,796	63,317,051		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	13,663,255	49,653,796	63,317,051		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 9:32 am
	Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
44.00	04400 SKILLED NURSING FACILITY		44.00
45.00	04500 NURSING FACILITY		45.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000	54.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC		88.00
90.00	09000 CLINIC	0.000000	90.00
90.01	09001 WOUND CARE	0.000000	90.01
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,954,539		2,954,539	0	2,954,539	30.00
31.00	03100 INTENSIVE CARE UNIT	411,147		411,147	0	411,147	31.00
43.00	04300 NURSERY	0		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	1,994,095		1,994,095	0	1,994,095	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,601,485		1,601,485	0	1,601,485	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	2,114,012		2,114,012	0	2,114,012	54.00
60.00	06000 LABORATORY	2,534,263		2,534,263	0	2,534,263	60.00
65.00	06500 RESPIRATORY THERAPY	385,936	0	385,936	0	385,936	65.00
66.00	06600 PHYSICAL THERAPY	1,143,850	0	1,143,850	0	1,143,850	66.00
69.00	06900 ELECTROCARDIOLOGY	78,698		78,698	0	78,698	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	979,402		979,402	0	979,402	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	69,752		69,752	0	69,752	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,555,869		1,555,869	0	1,555,869	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	3,984,260		3,984,260	0	3,984,260	88.00
90.00	09000 CLINIC	538,475		538,475	0	538,475	90.00
90.01	09001 WOUND CARE	366,472		366,472	0	366,472	90.01
91.00	09100 EMERGENCY	1,741,820		1,741,820	0	1,741,820	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	941,464		941,464	0	941,464	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	499,238		499,238		499,238	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,894,777	0	23,894,777	0	23,894,777	200.00
201.00	Less Observation Beds	941,464		941,464		941,464	201.00
202.00	Total (see instructions)	22,953,313	0	22,953,313	0	22,953,313	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/19/2014 9:32 am

		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,068,057		4,068,057		30.00
31.00	03100	INTENSIVE CARE UNIT	476,133		476,133		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	989,906		989,906		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	491,490	3,426,353	3,917,843	0.408767	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	935,118	14,189,349	15,124,467	0.139774	54.00
60.00	06000	LABORATORY	1,435,036	10,348,499	11,783,535	0.215068	60.00
65.00	06500	RESPIRATORY THERAPY	613,910	1,750,395	2,364,305	0.163234	65.00
66.00	06600	PHYSICAL THERAPY	1,068,528	1,754,734	2,823,262	0.405152	66.00
69.00	06900	ELECTROCARDIOLOGY	242,398	1,179,966	1,422,364	0.055329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,730,855	3,249,322	4,980,177	0.196660	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	12,838	148,896	161,734	0.431276	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,405,384	4,016,452	5,421,836	0.286963	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,149,837	3,149,837	1.264910	88.00
90.00	09000	CLINIC	0	1,072,572	1,072,572	0.502041	90.00
90.01	09001	WOUND CARE	998	735,089	736,087	0.497865	90.01
91.00	09100	EMERGENCY	82,990	3,314,848	3,397,838	0.512626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	109,614	809,993	919,607	1.023768	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	507,491	507,491		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	13,663,255	49,653,796	63,317,051		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	13,663,255	49,653,796	63,317,051		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 9:32 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000		54.00
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
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/19/2014 9:32 am
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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)	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	140,028	3,917,843	0.035741	286,421	10,237	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	116,138	15,124,467	0.007679	817,118	6,275	54.00
60.00	06000 LABORATORY	81,029	11,783,535	0.006876	1,314,351	9,037	60.00
65.00	06500 RESPIRATORY THERAPY	36,176	2,364,305	0.015301	481,078	7,361	65.00
66.00	06600 PHYSICAL THERAPY	81,259	2,823,262	0.028782	176,934	5,093	66.00
69.00	06900 ELECTROCARDIOLOGY	1,887	1,422,364	0.001327	165,340	219	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46,202	4,980,177	0.009277	1,121,808	10,407	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	1,068	161,734	0.006603	12,838	85	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	71,521	5,421,836	0.013191	1,070,858	14,126	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	316,303	3,149,837	0.100419	0	0	88.00
90.00	09000 CLINIC	38,313	1,072,572	0.035721	0	0	90.00
90.01	09001 WOUND CARE	42,952	736,087	0.058352	939	55	90.01
91.00	09100 EMERGENCY	70,144	3,397,838	0.020644	75,960	1,568	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	97,973	919,607	0.106538	78,647	8,379	92.00
200.00	Total (Lines 50-199)	1,140,993	57,275,464		5,602,292	72,842	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Title XVIII				Hospital	
		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
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
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: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 9:32 am

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		
					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	3,917,843	0.000000	0.000000	286,421	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	15,124,467	0.000000	0.000000	817,118	54.00
60.00	06000 LABORATORY	0	11,783,535	0.000000	0.000000	1,314,351	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,364,305	0.000000	0.000000	481,078	65.00
66.00	06600 PHYSICAL THERAPY	0	2,823,262	0.000000	0.000000	176,934	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,422,364	0.000000	0.000000	165,340	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,980,177	0.000000	0.000000	1,121,808	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	161,734	0.000000	0.000000	12,838	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,421,836	0.000000	0.000000	1,070,858	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	3,149,837	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,072,572	0.000000	0.000000	0	90.00
90.01	09001 WOUND CARE	0	736,087	0.000000	0.000000	939	90.01
91.00	09100 EMERGENCY	0	3,397,838	0.000000	0.000000	75,960	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	919,607	0.000000	0.000000	78,647	92.00
200.00	Total (Lines 50-199)	0	57,275,464			5,602,292	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet D
Part IV
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 WOUND CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
						1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.408767	0	1,325,357	0	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.139774	0	6,422,634	0	0	54.00
60.00	06000	LABORATORY	0.215068	0	5,362,193	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.163234	0	721,496	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.405152	0	654,257	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055329	0	484,644	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	0	1,245,660	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.431276	0	155,005	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.286963	0	2,365,958	875	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.502041	0	1,038,860	0	0	90.00
90.01	09001	WOUND CARE	0.497865	0	499,194	0	0	90.01
91.00	09100	EMERGENCY	0.512626	0	1,101,213	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	0	411,775	0	0	92.00
200.00		Subtotal (see instructions)		0	21,788,246	875	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	21,788,246	875	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	541,762	0		50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	897,717	0		54.00
60.00 06000 LABORATORY	1,153,236	0		60.00
65.00 06500 RESPIRATORY THERAPY	117,773	0		65.00
66.00 06600 PHYSICAL THERAPY	265,074	0		66.00
69.00 06900 ELECTROCARDIOLOGY	26,815	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	244,971	0		71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	66,850	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	678,942	251		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	521,550	0		90.00
90.01 09001 WOUND CARE	248,531	0		90.01
91.00 09100 EMERGENCY	564,510	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	421,562	0		92.00
200.00 Subtotal (see instructions)	5,749,293	251		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,749,293	251		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 9:32 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WOUND CARE	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 9:32 am PPS
		Title XVIII	Skilled Nursing Facility

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	3,917,843	0.000000	0.000000	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	15,124,467	0.000000	0.000000	21,219	54.00
60.00 06000 LABORATORY	0	11,783,535	0.000000	0.000000	75,414	60.00
65.00 06500 RESPIRATORY THERAPY	0	2,364,305	0.000000	0.000000	71,103	65.00
66.00 06600 PHYSICAL THERAPY	0	2,823,262	0.000000	0.000000	742,295	66.00
69.00 06900 ELECTROCARDIOLOGY	0	1,422,364	0.000000	0.000000	3,742	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,980,177	0.000000	0.000000	247,026	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	161,734	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,421,836	0.000000	0.000000	24,114	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	3,149,837	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	0	1,072,572	0.000000	0.000000	0	90.00
90.01 09001 WOUND CARE	0	736,087	0.000000	0.000000	59	90.01
91.00 09100 EMERGENCY	0	3,397,838	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	919,607	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	57,275,464			1,184,972	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 9:32 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CARE	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.408767	0	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.139774	0	0	0	0	54.00
60.00 06000 LABORATORY	0.215068	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.163234	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.405152	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.055329	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	0	0	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0.431276	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.286963	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00 09000 CLINIC	0.502041	0	0	0	0	90.00
90.01 09001 WOUND CARE	0.497865	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.512626	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2013	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am
	Component CCN: 145552	To 06/30/2014	
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 WOUND CARE	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.408767	0	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.139774	0	0	0	54.00
60.00	06000 LABORATORY	0.215068	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.163234	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.405152	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.055329	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	0	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.431276	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286963	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1.264910				88.00
90.00	09000 CLINIC	0.502041	0	0	0	90.00
90.01	09001 WOUND CARE	0.497865	0	0	0	90.01
91.00	09100 EMERGENCY	0.512626	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 9:32 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CARE	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 9:32 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,906	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,906	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,980	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)		1,681	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,954,539	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)		2,954,539	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,954,539	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,016.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,709,073	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,709,073	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
Date/Time Prepared: 11/19/2014 9:32 am		Title XVIII		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	411,147	473	869.23	154	133,861		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,326,698		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,169,632		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						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)						926	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,016.70	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						941,464	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 9:32 am	
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	307,460	2,954,539	0.104064	941,464	97,973	90.00
91.00	Nursing School cost	0	2,954,539	0.000000	941,464	0	91.00
92.00	Allied health cost	0	2,954,539	0.000000	941,464	0	92.00
93.00	All other Medical Education	0	2,954,539	0.000000	941,464	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Component CCN: 145552		Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,908	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,908	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)		6,908	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)		1,850	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,994,095	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,994,095	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,994,095	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Component CCN: 145552		Date/Time Prepared: 11/19/2014 9:32 am			
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					1,994,095	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					288.66	71.00
72.00	Program routine service cost (line 9 x line 71)					534,021	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					534,021	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					534,021	83.00
84.00	Program inpatient ancillary services (see instructions)					387,269	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					921,290	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: 141311 Component CCN: 145552		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 9:32 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 9:32 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,906 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,906 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,980 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)			201 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			188.27 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			192.90 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,954,539 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)			2,954,539 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,954,539 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,016.70 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			204,357 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)			204,357 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
Date/Time Prepared: 11/19/2014 9:32 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
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	411,147	473	869.23	16	13,908		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						218,265	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						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)						926	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,016.70	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						941,464	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 9:32 am	
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	307,460	2,954,539	0.104064	941,464	97,973	90.00
91.00	Nursing School cost	0	2,954,539	0.000000	941,464	0	91.00
92.00	Allied health cost	0	2,954,539	0.000000	941,464	0	92.00
93.00	All other Medical Education	0	2,954,539	0.000000	941,464	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 9:32 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,629,472		30.00
31.00	03100 INTENSIVE CARE UNIT		354,699		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.408767	286,421	117,079	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.139774	817,118	114,212	54.00
60.00	06000 LABORATORY	0.215068	1,314,351	282,675	60.00
65.00	06500 RESPIRATORY THERAPY	0.163234	481,078	78,528	65.00
66.00	06600 PHYSICAL THERAPY	0.405152	176,934	71,685	66.00
69.00	06900 ELECTROCARDIOLOGY	0.055329	165,340	9,148	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	1,121,808	220,615	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.431276	12,838	5,537	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286963	1,070,858	307,297	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.502041	0	0	90.00
90.01	09001 WOUND CARE	0.497865	939	467	90.01
91.00	09100 EMERGENCY	0.512626	75,960	38,939	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	78,647	80,516	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,602,292	1,326,698	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		5,602,292		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3	
		Component CCN: 145552		Date/Time Prepared: 11/19/2014 9:32 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.408767	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.139774	21,219	54.00
60.00	06000	LABORATORY	0.215068	75,414	60.00
65.00	06500	RESPIRATORY THERAPY	0.163234	71,103	65.00
66.00	06600	PHYSICAL THERAPY	0.405152	742,295	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055329	3,742	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	247,026	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.431276	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.286963	24,114	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.502041	0	90.00
90.01	09001	WOUND CARE	0.497865	59	90.01
91.00	09100	EMERGENCY	0.512626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,184,972	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,184,972	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 9:32 am	
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
31.00	03100 INTENSIVE CARE UNIT		0		31.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.408767	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.139774	0	0	54.00
60.00	06000 LABORATORY	0.215068	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.163234	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.405152	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.055329	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196660	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.431276	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.286963	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.264910	0	0	88.00
90.00	09000 CLINIC	0.502041	0	0	90.00
90.01	09001 WOUND CARE	0.497865	0	0	90.01
91.00	09100 EMERGENCY	0.512626	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.023768	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/19/2014 9:32 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,749,544 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,749,544 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,807,039 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			109,655 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,321,273 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)			2,376,111 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)			2,376,111 30.00
31.00	Primary payer payments			1,553 31.00
32.00	Subtotal (line 30 minus line 31)			2,374,558 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)			733,676 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			645,635 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			674,224 36.00
37.00	Subtotal (see instructions)			3,020,193 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,020,193 40.00
40.01	Sequestration adjustment (see instructions)			60,404 40.01
41.00	Interim payments			3,305,409 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-345,620 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			142,153 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/19/2014 9:32 am
		Component CCN: 145552	Title XVIII	Skilled Nursing Facility
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/19/2014 9:32 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,285,000		3,305,409	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)		2,285,000		3,305,409	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		398,901		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		345,620	6.02	
7.00	Total Medicare program liability (see instructions)		2,683,901		2,959,789	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: 141311
Component CCN: 145552

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
11/19/2014 9:32 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		592,209		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)		592,209		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		592,209		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			769 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,835 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			10 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,453 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			63,317,051 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			860,638 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			3,169,632 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			3,169,632 4.00
5.00	Primary payer payments			5,631 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,195,697 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,195,697 19.00
20.00	Deductibles (exclude professional component)			524,967 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,670,730 22.00
23.00	Coinsurance			3,920 23.00
24.00	Subtotal (line 22 minus line 23)			2,666,810 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			81,664 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			71,864 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			71,802 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,738,674 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,738,674 30.00
30.01	Sequestration adjustment (see instructions)			54,773 30.01
31.00	Interim payments			2,285,000 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			398,901 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			78,375 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		722,509	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		722,509	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		3,942	6.00
7.00	Coinsurance		114,272	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		604,295	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		604,295	15.00
15.01	Sequestration adjustment (see instructions)		12,086	15.01
16.00	Interim payments		592,209	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet G

Date/Time Prepared:
11/19/2014 9:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	595,089	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,569,458	0	0	0	4.00
5.00	Other receivable	370,672	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,795,532	0	0	0	6.00
7.00	Inventory	292,309	0	0	0	7.00
8.00	Prepaid expenses	200,553	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,232,549	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	35,912,845	0	0	0	15.00
16.00	Accumulated depreciation	-19,953,287	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,959,558	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	42,177	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,164,455	0	0	0	33.00
34.00	Other assets	1,115,378	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,322,010	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,514,117	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,315,402	0	0	0	37.00
38.00	Salaries, wages, and fees payable	336,166	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	837,328	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	863,549	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,352,445	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,312,826	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,312,826	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,665,271	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	13,848,846	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,848,846	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,514,117	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-1

Date/Time Prepared:
11/19/2014 9:32 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		13,304,242		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		544,604			2.00
3.00	Total (sum of line 1 and line 2)		13,848,846		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)		13,848,846		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)		13,848,846		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: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2014 9:32 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,987,664		4,987,664	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	989,906		989,906	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)	5,977,570		5,977,570	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	476,133		476,133	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	476,133		476,133	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,453,703		6,453,703	17.00
18.00	Ancillary services	8,018,547	44,114,902	52,133,449	18.00
19.00	Outpatient services	0	1,072,572	1,072,572	19.00
20.00	RURAL HEALTH CLINIC	0	3,149,837	3,149,837	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		507,491	507,491	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	259,845	5,326,558	5,586,403	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,732,095	54,171,360	68,903,455	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,253,125		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	WAYFAIR	130,648			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)		130,648		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,122,477		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141311

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-3

Date/Time Prepared:
11/19/2014 9:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	68,903,455	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,208,175	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,695,280	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,122,477	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-427,197	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	829,856	24.00
24.01	NON OPERATING REVENUE	141,945	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	971,801	25.00
26.00	Total (line 5 plus line 25)	544,604	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)	544,604	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311

Period: From 07/01/2013

Worksheet H

HHA CCN: 147612

To 06/30/2014

Date/Time Prepared: 11/19/2014 9:32 am

Home Health Agency I

PPS

	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	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	28,917	0	30,748	1,286	28,068	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	131,611	0	0	0	131,611	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 Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	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	DIRECTOR	79,019	0	0	0	79,019	23.00
24.00	Total (sum of lines 1-23)	239,547	0	30,748	1,286	28,068	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	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	89,019	0	89,019		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	131,611	0	131,611		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	0	0	0		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	DIRECTOR	0	79,019	0	79,019		23.00
24.00	Total (sum of lines 1-23)	0	299,649	0	299,649		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: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet H-1 Part I Date/Time Prepared: 11/19/2014 9:32 am
		HHA CCN: 147612	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)	
		Bl dgs & Fixtures	Movable Equipment				
		1.00	2.00				
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	89,019	0	0	0	89,019	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	131,611	0	0	0	131,611	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 Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	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	DIRECTOR	79,019	0	0	0	79,019	23.00
24.00	Total (sum of lines 1-23)	299,649	0	0	0	299,649	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	89,019					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	55,623	187,234				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	0	0				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	DIRECTOR	33,396	112,415				23.00
24.00	Total (sum of lines 1-23)		299,649				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141311

Period: From 07/01/2013

Worksheet H-1

HHA CCN: 147612

To 06/30/2014

Part II
Date/Time Prepared:
11/19/2014 9:32 am

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	-89,019	210,630
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	131,611
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	0
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	DIRECTOR	0	0	0	0	0	79,019
24.00	Total (sum of lines 1-23)	0	0	0	0	-89,019	210,630
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	89,019
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.422632

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311

Period: From 07/01/2013

Worksheet H-2

HHA CCN: 147612

To 06/30/2014

Part I
Date/Time Prepared: 11/19/2014 9:32 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	24,242	6,726	6,571	37,539	5,473	1.00	
2.00 Skilled Nursing Care	187,234	0	0	29,908	217,142	31,658	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 DIRECTOR	112,415	0	0	17,957	130,372	19,008	19.00	
20.00 Total (sum of lines 1-19) (2)	299,649	24,242	6,726	54,436	385,053	56,139	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	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	6.00	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	20,992	18,482	0	18,572	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 DIRECTOR	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	20,992	18,482	0	18,572	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(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: 141311

Period: From 07/01/2013

Worksheet H-2 Part I

HHA CCN: 147612

To 06/30/2014

Date/Time Prepared: 11/19/2014 9:32 am

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		13.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	101,058	0	101,058	1.00
2.00	Skilled Nursing Care	0	0	0	248,800	0	248,800	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	DIRECTOR	0	0	0	149,380	0	149,380	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	499,238	0	499,238	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	63,145	311,945					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	DIRECTOR	37,913	187,293					19.00
20.00	Total (sum of lines 1-19) (2)	101,058	499,238					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.	0.253800						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: 141311
HHA CCN: 147612

Period:
From 07/01/2013
To 06/30/2014

Worksheet H-2
Part II
Date/Time Prepared:
11/19/2014 9:32 am

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	1,920	1,920	28,917	0	37,539	1,920	1.00
2.00 Skilled Nursing Care	0	0	131,611	0	217,142	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 DIRECTOR	0	0	79,019	0	130,372	0	19.00
20.00 Total (sum of lines 1-19)	1,920	1,920	239,547		385,053	1,920	20.00
21.00 Total cost to be allocated	24,242	6,726	54,436		56,139	20,992	21.00
22.00 Unit cost multiplier	12.626042	3.503125	0.227246		0.145796	10.933333	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	1,920	0	1,920	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00 Total cost to be allocated	18,482	0	18,572	0	0	0	21.00
22.00 Unit cost multiplier	9.626042	0.000000	9.672917	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311
HHA CCN: 147612

Period:
From 07/01/2013
To 06/30/2014

Worksheet H-2
Part II
Date/Time Prepared:
11/19/2014 9:32 am
PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet H-3 Part I Date/Time Prepared: 11/19/2014 9:32 am
		HHA CCN: 147612	Title XVIII	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	311,945		311,945	1,978	157.71	1.00
2.00	Physical Therapy	3.00	0	0	0	912	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	174	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	49	0.00	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	0	0	0	1	0.00	6.00
7.00	Total (sum of lines 1-6)		311,945	0	311,945	3,114		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		14999	359	1,396		8.00
9.00	Physical Therapy		14999	219	565		9.00
10.00	Occupational Therapy		14999	22	115		10.00
11.00	Speech Pathology		14999	11	20		11.00
12.00	Medical Social Services		14999	0	0		12.00
13.00	Home Health Aide		14999	0	0		13.00
14.00	Total (sum of lines 8-13)			611	2,096		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00	

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	359	1,396		56,618	220,163	1.00
2.00	Physical Therapy	219	565		0	0	2.00
3.00	Occupational Therapy	22	115		0	0	3.00
4.00	Speech Pathology	11	20		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	0		0	0	6.00
7.00	Total (sum of lines 1-6)	611	2,096		56,618	220,163	7.00

Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00
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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: 141311	Period: From 07/01/2013	Worksheet H-3
	HHA CCN: 147612	To 06/30/2014	Part I Date/Time Prepared: 11/19/2014 9:32 am
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Program Covered Charges			Cost of Services	Part B			
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies		0			0	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	276,781					1.00	
2.00	Physical Therapy	0					2.00	
3.00	Occupational Therapy	0					3.00	
4.00	Speech Pathology	0					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	0					6.00	
7.00	Total (sum of lines 1-6)	276,781					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: 141311 HHA CCN: 147612	Period: From 07/01/2013 To 06/30/2014	Worksheet H-3 Part II Date/Time Prepared: 11/19/2014 9:32 am
		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	0.405152	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.196660	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.286963	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 141311	Period: From 07/01/2013	Worksheet H-4
	HHA CCN: 147612	To 06/30/2014	Part I-II Date/Time Prepared: 11/19/2014 9:32 am
	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	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

	Part A Services	Part B Services	
	1.00	2.00	

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	97,666	286,406	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	7,358	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	820	7,913	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	742	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	7,368	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	98,486	309,787	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	98,486	309,787	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	98,486	309,787	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	98,486	309,787	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	98,486	309,787	31.00
31.01	Sequestration adjustment (see instructions)	1,970	6,196	31.01
32.00	Interim payments (see instructions)	96,516	303,591	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 141311
HHA CCN: 147612

Period:
From 07/01/2013
To 06/30/2014

Worksheet H-5
Date/Time Prepared:
11/19/2014 9:32 am
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		96,516		303,591	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		96,516		303,591	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		96,516		303,591	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2013 To 06/30/2014	Worksheet M-1 Date/Time Prepared: 11/19/2014 9:32 am
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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)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,154,989	0	1,154,989	0	1,154,989	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	209,400	0	209,400	0	209,400	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,364,389	0	1,364,389	0	1,364,389	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	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,364,389	0	1,364,389	0	1,364,389	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	0	0	0	0	29.00
30.00	Administrative Costs	654,407	289,734	944,141	-407	943,734	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	654,407	289,734	944,141	-407	943,734	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,018,796	289,734	2,308,530	-407	2,308,123	32.00

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

Provider CCN: 141311
Component CCN: 148500

Period:
From 07/01/2013
To 06/30/2014

Worksheet M-1
Date/Time Prepared:
11/19/2014 9:32 am
Rural Health Clinic (RHC) I
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,154,989	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	209,400	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	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	1,364,389	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	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,364,389	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	0	29.00
30.00	Administrative Costs	0	943,734	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	943,734	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,308,123	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2013 To 06/30/2014	Worksheet M-2 Date/Time Prepared: 11/19/2014 9:32 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	3.58	13,748	4,200	15,036	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.67	4,733	2,100	3,507	3.00
4.00	Subtotal (sum of lines 1-3)	5.25	18,481		18,543	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)	5.25	18,481		18,543	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				1,364,389	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,364,389	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)				943,734	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,676,137	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,619,871	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				2,619,871	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				2,619,871	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				3,984,260	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141311	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3
		Component CCN: 148500		Date/Time Prepared: 11/19/2014 9:32 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		3,984,260	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,984,260	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		18,543	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)		18,543	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		214.87	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. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	214.87	214.87	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,749	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,450,158	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,450,158	16.00
16.01	Total program charges (see instructions)(from contractor's records)		742,938	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		688	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,343	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,084,804	16.04
16.05	Total program cost (see instructions)		1,086,147	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		92,810	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		129,888	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,086,147	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,086,147	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable 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 (see instructions)		1,086,147	26.00
26.01	Sequestration adjustment (see instructions)		21,723	26.01
27.00	Interim payments		994,070	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		70,354	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		28,367	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 11/19/2014 9:32 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		952,270	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		02/13/2014	41,800	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)		41,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		994,070	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		70,354	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,064,424	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00