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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 140059

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

Worksheet S
Parts I-III
Date/Time Prepared:
11/21/2013 10:09 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2013 Time: 10:09 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JERSEY COMMUNITY HOSPITAL DIST (140059) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-18,127	-35,633	153,790	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-21	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5,986		0	10.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-18,148	-29,647	153,790	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 MAPLE SUMMIT ROAD	PO Box:			1.00
2.00	City: JERSEYVILLE	State: IL	Zip Code: 62052	County: JERSEY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	JERSEY COMMUNITY HOSPITAL DIST	140059	41180	1	07/11/1966	N	P	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	JERSEY COMMUNITY HOSPITAL	14U059	41180		08/27/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OB/GYN ASSOCIATES	148509	41180		04/05/2010	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	439	58	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		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.	1		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.	07/01/2012	06/30/2013	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)	Y	Y	39.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	Y	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	10.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00

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		V	XIX	
		1.00	2.00	
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)			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.					109.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,000,000	8,000,000	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2012	06/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2013 10:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2013 10:08 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	DAVE	KENNETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	JERSEY COMMUNITY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-498-8350	DKENNETT@JCH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2013 10:08 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	10/23/2013			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR OF FINANCE		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

VOLUNTARY CONTACT INFORMATION | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part V | Date/Time Prepared: 11/21/2013 10:08 pm

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	DAVE	13.00
14.00	Last Name	KENNETT	14.00
15.00	Title	DIRECTOR OF FINANCE	15.00
16.00	Employer	JERSEY COMMUNITY HOSPITAL	16.00
17.00	Phone Number	(619)498-8350	17.00
18.00	E-mail Address	DKENNETT@JCH.ORG	18.00
19.00	Department	FINANCE	19.00
20.00	Mailing Address 1	400 MAPLE SUMMIT ROAD	20.00
21.00	Mailing Address 2		21.00
22.00	City	JERSEYVILLE	22.00
23.00	State	IL	23.00
24.00	Zip	62052	24.00

HFS Supplemental Information | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part IX | Date/Time Prepared: 11/21/2013 10:08 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	41	14,965	0.00	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)		41	14,965	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	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)		45	16,425	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		45				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,356	370	3,192			1.00
2.00	HMO and other (see instructions)	67	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	72	0	72			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)	2,428	370	3,264			7.00
8.00	INTENSIVE CARE UNIT	171	19	253			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		108	212			13.00
14.00	Total (see instructions)	2,599	497	3,729	0.00	235.96	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	94	0	3,294	0.00	4.69	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	240.65	27.00
28.00	Observation Bed Days		41	278			28.00
29.00	Ambulance Trips	1,672					29.00
30.00	Employee discount days (see instruction)			18			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	747	267	1,143	1.00
2.00	HMO and other (see instructions)			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	747	267	1,143	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2013 10:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	11,364,058	0	11,364,058	500,552.00	22.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		779,426	0	779,426	9,762.00	79.84	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,314,019	0	1,314,019	63,249.00	20.78	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		1,079,671	0	1,079,671	17,002.00	63.50	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,738,792	0	2,738,792			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		398,447	0	398,447			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		128,970	0	128,970			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	144,866	0	144,866	5,718.00	25.34	26.00
27.00	Administrative & General	5.00	1,439,773	0	1,439,773	70,398.00	20.45	27.00
28.00	Administrative & General under contract (see inst.)		38,466	0	38,466	199.00	193.30	28.00
29.00	Maintenance & Repairs	6.00	190,292	0	190,292	6,291.00	30.25	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	64,450	0	64,450	5,093.00	12.65	31.00
32.00	Housekeeping	9.00	224,663	0	224,663	20,711.00	10.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	295,136	0	295,136	24,516.00	12.04	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	547,515	0	547,515	17,624.00	31.07	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	332,047	0	332,047	20,993.00	15.82	41.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2013 10:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part III Date/Time Prepared: 11/21/2013 10:08 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		10,623,098	0	10,623,098	490,989.00	21.64	1.00
2.00	Excluded area salaries (see instructions)		1,314,019	0	1,314,019	63,249.00	20.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,309,079	0	9,309,079	427,740.00	21.76	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,079,671	0	1,079,671	17,002.00	63.50	4.00
5.00	Subtotal wage-related costs (see inst.)		2,738,792	0	2,738,792	0.00	29.42	5.00
6.00	Total (sum of lines 3 thru 5)		13,127,542	0	13,127,542	444,742.00	29.52	6.00
7.00	Total overhead cost (see instructions)		3,277,208	0	3,277,208	171,543.00	19.10	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part IV | Date/Time Prepared: 11/21/2013 10:08 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	368,088	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)	1,912,395	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)	0	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	175,828	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	785,872	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	24,026	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,266,209	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part V | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,118,138	0	1.00
2.00	Hospital	1,118,138	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/21/2013 10:08 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	08/27/1993	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	5	5	20.00
21.00		RMC	0	6	6	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	10	10	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	5	5	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	17	17	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	22	22	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-7 | Date/Time Prepared: 11/21/2013 10:08 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	7	7	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	72	72	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	41180	41180	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)	0			207.00

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

Provider CCN: 140059 Component CCN: 148509 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 11/21/2013 10:08 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1702 W COUNTY RD	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	JERSEYVILLE	IL	62052	2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	16:00	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			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		JERSEY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	09:00	16:00	09:00	16:00	11.00

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

Provider CCN: 140059
Component CCN: 148509

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

Worksheet S-8

Date/Time Prepared:
11/21/2013 10:08 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	12:00	09:00	11:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140059	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/21/2013 10:08 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.418896	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,941,024	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,675,503	6.00
7.00	Medicaid cost (line 1 times line 6)	3,634,134	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)	693,110	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)	693,110	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	216,980	25,425	242,405	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	90,892	10,650	101,542	21.00
22.00	Partial payment by patients approved for charity care	14,309	12,181	26,490	22.00
23.00	Cost of charity care (line 21 minus line 22)	76,583	-1,531	75,052	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)	2,632,660	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	217,074	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	2,415,586	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,011,879	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,086,931	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,780,041	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,082,871	1,082,871	65,269	1,148,140	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		682,269	682,269	762,554	1,444,823	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,866	3,108,748	3,253,614	175,828	3,429,442	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,439,773	4,992,632	6,432,405	-237,849	6,194,556	5.00
6.00	00600	MAINTENANCE & REPAIRS	190,292	344,320	534,612	0	534,612	6.00
7.00	00700	OPERATION OF PLANT	0	517,870	517,870	-29,498	488,372	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,450	13,780	78,230	0	78,230	8.00
9.00	00900	HOUSEKEEPING	224,663	47,400	272,063	0	272,063	9.00
10.00	01000	DIETARY	295,136	223,111	518,247	0	518,247	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	547,515	27,833	575,348	0	575,348	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,797	20,797	0	20,797	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	332,047	39,492	371,539	0	371,539	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	610,225	610,225	0	610,225	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,359,974	103,393	1,463,367	-9,436	1,453,931	30.00
31.00	03100	INTENSIVE CARE UNIT	399,034	7,741	406,775	0	406,775	31.00
43.00	04300	NURSERY	46,556	0	46,556	0	46,556	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	341,410	479,923	821,333	-63,153	758,180	50.00
51.00	05100	RECOVERY ROOM	111,414	0	111,414	0	111,414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,034	0	47,034	0	47,034	52.00
53.00	05300	ANESTHESIOLOGY	0	40,879	40,879	0	40,879	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	724,635	1,245,569	1,970,204	-735,792	1,234,412	54.00
60.00	06000	LABORATORY	896,150	957,296	1,853,446	-3,249	1,850,197	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,025,149	1,025,149	0	1,025,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	240,833	67,550	308,383	-17,325	291,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	665,934	665,934	-32,227	633,707	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	95,380	95,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	345,857	1,505,687	1,851,544	0	1,851,544	73.00
75.00	07500	ASC (NON-DISTINCT PART)	534,445	116,085	650,530	0	650,530	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	779,426	162,271	941,697	0	941,697	88.00
91.00	09100	EMERGENCY	984,529	2,064,754	3,049,283	0	3,049,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	660,360	80,923	741,283	0	741,283	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,710,399	20,234,502	30,944,901	-29,498	30,915,403	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	357,874	125,225	483,099	29,498	512,597	192.00
192.01	19201	WELLNESS CENTER	295,785	139,081	434,866	0	434,866	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	11,364,058	20,498,808	31,862,866	0	31,862,866	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-64,763	1,083,377		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,444,823		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-636,977	2,792,465		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,251,716	2,942,840		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	534,612		6.00
7.00	00700	OPERATION OF PLANT	0	488,372		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,230		8.00
9.00	00900	HOUSEKEEPING	0	272,063		9.00
10.00	01000	DIETARY	-127,275	390,972		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	575,348		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,797		14.00
15.00	01500	PHARMACY	-321,806	-321,806		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,781	358,758		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-610,225	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,453,931		30.00
31.00	03100	INTENSIVE CARE UNIT	0	406,775		31.00
43.00	04300	NURSERY	0	46,556		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	758,180		50.00
51.00	05100	RECOVERY ROOM	0	111,414		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,034		52.00
53.00	05300	ANESTHESIOLOGY	0	40,879		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	1,234,412		54.00
60.00	06000	LABORATORY	-2,810	1,847,387		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,025,149		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	291,058		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	633,707		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	95,380		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,851,544		73.00
75.00	07500	ASC (NON-DISTINCT PART)	-100	650,430		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-173,885	767,812		88.00
91.00	09100	EMERGENCY	-1,956,634	1,092,649		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-11,688	729,595		95.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
106.00	10600	HEART ACQUISITION	0	0		106.00
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW - SNF	0	0		114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,170,660	23,744,743		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	512,597		192.00
192.01	19201	WELLNESS CENTER	-706	434,160		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,171,366	24,691,500		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY - DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
99.00	CMHC	09900		99.00
99.10	CORF	09910		99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	10000		100.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
106.00	HEART ACQUISITION	10600		106.00
113.00	INTEREST EXPENSE	11300		113.00
114.00	UTILIZATION REVIEW - SNF	11400		114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	WELLNESS CENTER	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/21/2013 10:08 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS	4.00	0	175,828		1.00
	TOTALS		0	175,828		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	47,346		1.00
	TOTALS		0	47,346		
	C - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,390		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	749,087		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	780,477		
	D - PHYSICIAN OFFICE EXPENSE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	29,498		1.00
	TOTALS		0	29,498		
	E - TO RECLASS IMPLANTABLE SUPPLIES					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	95,380		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	95,380		
500.00	Grand Total: Increases		0	1,128,529		500.00

RECLASSIFICATIONS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/21/2013 10:08 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - WORKERS COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	175,828	0		1.00
	TOTALS		0	175,828			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	47,346	12		1.00
	TOTALS		0	47,346			
	C - RENTAL EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	9,436	10		1.00
2.00	LABORATORY	60.00	0	3,249	10		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	17,325	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	14,675	0		4.00
5.00	RADIOLOGY - DIAGNOSTIC	54.00	0	735,792	0		5.00
	TOTALS		0	780,477			
	D - PHYSICIAN OFFICE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	29,498	0		1.00
	TOTALS		0	29,498			
	E - TO RECLASS IMPLANTABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32,227	0		1.00
2.00	OPERATING ROOM	50.00	0	63,153	0		2.00
	TOTALS		0	95,380			
500.00	Grand Total: Decreases		0	1,128,529			500.00

RECLASSIFICATIONS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 11/21/2013 10:08 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - WORKERS COMPENSATION						
1.00	EMPLOYEE BENEFITS	4.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	B - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		0	TOTALS		0	
	C - RENTAL EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADULTS & PEDIATRICS	30.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	LABORATORY	60.00	0	2.00
3.00		0.00	0	ELECTROCARDIOLOGY	69.00	0	3.00
4.00		0.00	0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00		0.00	0	RADIOLOGY - DIAGNOSTIC	54.00	0	5.00
	TOTALS		0	TOTALS		0	
	D - PHYSICIAN OFFICE EXPENSE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	OPERATION OF PLANT	7.00	0	1.00
	TOTALS		0	TOTALS		0	
	E - TO RECLASS IMPLANTABLE SUPPLIES						
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1.00
2.00		0.00	0	OPERATING ROOM	50.00	0	2.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		0	Grand Total: Decreases		0	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	55,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,587,605	3,995,570	0	3,995,570	0	3.00
4.00	Building Improvements	5,008,443	127,039	0	127,039	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,663,811	975,635	0	975,635	189,617	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,314,859	5,098,244	0	5,098,244	189,617	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,314,859	5,098,244	0	5,098,244	189,617	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	55,000	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	18,583,175	0	3.00
4.00	Building Improvements	5,135,482	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,449,829	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,223,486	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,223,486	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	751,517	0	331,354	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	682,269	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,433,786	0	331,354	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	1,082,871	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	682,269	2.00
3.00	Total (sum of lines 1-2)	0	1,765,140	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,773,658	0	23,773,658	0.715568	33,879	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,449,829	0	9,449,829	0.284432	13,467	2.00
3.00	Total (sum of lines 1-2)	33,223,487	0	33,223,487	1.000000	47,346	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	33,879	751,359	31,390	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,467	682,269	749,087	2.00
3.00	Total (sum of lines 1-2)	0	0	47,346	1,433,628	780,477	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	266,749	33,879	0	0	1,083,377	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,467	0	0	1,444,823	2.00
3.00	Total (sum of lines 1-2)	266,749	47,346	0	0	2,528,200	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,605	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	A	-26,954	ADMINISTRATIVE & GENERAL	5.00	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)	B	-1,330	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-158	CAP REL COSTS-BLDG & FIXT	1.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,129,724			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-126,827	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others	B	-296,179	ADMINISTRATIVE & GENERAL	5.00	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	B	-321,806	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,781	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-448	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-610,225	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REV	B	-12,350	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EDUCATIONAL PROGRAM FEES	B	-11,688	AMBULANCE SERVICES	95.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OBSTETRICS -OTHER REV	B	-795	RURAL HEALTH CLINIC	88.00	0	33.02
33.03			0		0.00	0	33.03
33.04	NON PATIENT LAB REV	B	-2,810	LABORATORY	60.00	0	33.04
33.05	LIFE LINE REVENUE	B	-45,542	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	BAD DEBTS	A	-2,632,654	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SELF INSURANCE CLAIMS	A	-611,799	EMPLOYEE BENEFITS	4.00	0	33.07
33.08	ADVERTISING	A	-94,408	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MARKETING SALARIES	A	-55,733	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MARKETING BENEFITS	A	-15,204	EMPLOYEE BENEFITS	4.00	0	33.10
33.11	LOBBYING EXPENSES	A	-16,687	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PROPERTY TAXES	B	-10,608	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PERSONNEL OTHER INCOME	B	-66	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ADVERTISING	A	-706	WELLNESS CENTER	192.01	0	33.14
33.15	MISCELLANEOUS EXPENSE	A	-20,303	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ELIMINATE LOSS ON DISPOSAL	A	-2,003	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	FOUNDATION SALARIES	A	-36,561	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	FOUNDATION BENEFITS	A	-9,974	EMPLOYEE BENEFITS	4.00	0	33.18
33.19	RECYCLING REVENUE - MISC	B	-338	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	DIABETES MISC REVENUE	B	-100	ASC (NON-DISTINCT PART)	75.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,171,366				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2013 10:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	88.00	RURAL HEALTH CLINIC	173,090	173,090	0	0	0	1.00
2.00	91.00	EMERGENCY	1,956,634	1,956,634	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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			2,129,724	2,129,724	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		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	88.00	RURAL HEALTH CLINIC	0	0	0	173,090		1.00
2.00	91.00	EMERGENCY	0	0	0	1,956,634		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		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	2,129,724		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,083,377	1,083,377				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,444,823		1,444,823			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,792,465	3,232	61	2,795,758		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,942,840	44,061	188,804	358,786	3,534,491	5.00
6.00	00600	MAINTENANCE & REPAIRS	534,612	0	0	47,420	582,032	6.00
7.00	00700	OPERATION OF PLANT	488,372	33,779	0	0	522,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,230	9,368	2,179	16,061	105,838	8.00
9.00	00900	HOUSEKEEPING	272,063	683	2,716	55,985	331,447	9.00
10.00	01000	DIETARY	390,972	36,607	4,647	73,546	505,772	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	575,348	10,349	0	136,437	722,134	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,797	51,226	0	0	72,023	14.00
15.00	01500	PHARMACY	-321,806	13,869	24,133	0	-283,804	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	358,758	19,958	10,047	82,744	471,507	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,453,931	132,855	59,286	338,897	1,984,969	30.00
31.00	03100	INTENSIVE CARE UNIT	406,775	13,052	4,107	99,437	523,371	31.00
43.00	04300	NURSERY	46,556	10,416	758	11,601	69,331	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	758,180	45,224	74,849	85,077	963,330	50.00
51.00	05100	RECOVERY ROOM	111,414	4,607	0	27,764	143,785	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,034	19,804	0	11,721	78,559	52.00
53.00	05300	ANESTHESIOLOGY	40,879	981	13,462	0	55,322	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,234,412	61,210	885,422	180,575	2,361,619	54.00
60.00	06000	LABORATORY	1,847,387	23,661	34,670	223,315	2,129,033	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,025,149	34,904	6,253	0	1,066,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	291,058	44,147	20,172	60,014	415,391	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	633,707	0	0	0	633,707	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	95,380	0	0	0	95,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,851,544	0	0	86,185	1,937,729	73.00
75.00	07500	ASC (NON-DISTINCT PART)	650,430	46,975	10,821	133,180	841,406	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	767,812	24,045	0	194,228	986,085	88.00
91.00	09100	EMERGENCY	1,092,649	77,551	67,363	245,339	1,482,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	729,595	23,661	12,397	164,558	930,211	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,744,743	786,225	1,422,147	2,632,870	23,262,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,876	0	0	3,876	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	512,597	48,033	0	89,180	649,810	192.00
192.01	19201	WELLNESS CENTER	434,160	245,243	22,676	73,708	775,787	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	24,691,500	1,083,377	1,444,823	2,795,758	24,691,500	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		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	3,534,491					5.00
6.00	00600	MAINTENANCE & REPAIRS	95,947	677,979				6.00
7.00	00700	OPERATION OF PLANT	86,076	22,104	630,331			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,447	6,130	5,891	135,306		8.00
9.00	00900	HOUSEKEEPING	54,639	447	429	6,651	393,613	9.00
10.00	01000	DIETARY	83,376	23,954	23,021	0	23,728	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	119,043	6,772	6,508	0	2,792	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,873	33,521	32,215	234	2,792	14.00
15.00	01500	PHARMACY	0	9,076	8,722	0	4,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,727	13,060	12,551	0	6,979	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	327,220	86,936	83,550	41,134	127,016	30.00
31.00	03100	INTENSIVE CARE UNIT	86,277	8,541	8,208	7,430	12,562	31.00
43.00	04300	NURSERY	11,429	6,816	6,551	0	1,396	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,804	29,593	28,441	7,570	47,457	50.00
51.00	05100	RECOVERY ROOM	23,703	3,015	2,897	0	1,396	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,950	12,959	12,454	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,120	642	617	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	389,306	40,054	38,494	18,706	25,124	54.00
60.00	06000	LABORATORY	350,969	15,483	14,880	0	18,145	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	175,779	22,840	21,951	4,657	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	68,477	28,888	27,763	2,368	9,771	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104,466	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	15,723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	319,433	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	138,705	30,739	29,542	11,464	27,916	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	162,555	15,734	15,122	1,262	0	88.00
91.00	09100	EMERGENCY	244,455	50,747	48,770	27,678	51,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	153,344	15,483	14,880	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,298,843	483,534	443,457	129,154	362,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	639	2,536	2,438	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107,121	31,431	30,207	0	0	192.00
192.01	19201	WELLNESS CENTER	127,888	160,478	154,229	6,152	27,916	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	2,792	193.00
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)	3,534,491	677,979	630,331	135,306	393,613	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	659,851					10.00
11.00	01100	CAFETERIA	524,704	524,704				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	857,249			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	152,658		14.00
15.00	01500	PHARMACY	0	17,726	0	0	-244,093	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,044	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,700	102,814	284,496	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,447	19,499	69,923	0	0	31.00
43.00	04300	NURSERY	0	0	9,308	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,453	48,289	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	15,144	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	72,679	0	0	0	54.00
60.00	06000	LABORATORY	0	69,133	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,773	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,318	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	145,270	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	7,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	69,133	79,953	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	79,769	176,122	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,091	174,014	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	659,851	503,432	857,249	152,658	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	21,272	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	-244,093	201.00
202.00		TOTAL (sum lines 118-201)	659,851	524,704	857,249	152,658	-244,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	604,868					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	188,814	0	3,352,649	0	3,352,649	30.00
31.00	03100	INTENSIVE CARE UNIT	30,758	0	776,016	0	776,016	31.00
43.00	04300	NURSERY	0	0	104,831	0	104,831	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,761	0	1,341,698	0	1,341,698	50.00
51.00	05100	RECOVERY ROOM	0	0	189,940	0	189,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	116,922	0	116,922	52.00
53.00	05300	ANESTHESIOLOGY	0	0	65,701	0	65,701	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	184,877	0	3,130,859	0	3,130,859	54.00
60.00	06000	LABORATORY	65,740	0	2,663,383	0	2,663,383	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,293,306	0	1,293,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,957	0	591,933	0	591,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	883,443	0	883,443	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	118,491	0	118,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,257,162	0	2,257,162	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,228,858	0	1,228,858	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,180,758	0	1,180,758	88.00
91.00	09100	EMERGENCY	0	0	2,162,087	0	2,162,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	77,961	0	1,372,984	0	1,372,984	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	604,868	0	22,831,021	0	22,831,021	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	9,489	0	9,489	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	818,569	0	818,569	192.00
192.01	19201	WELLNESS CENTER	0	0	1,273,722	0	1,273,722	192.01
193.00	19300	NONPAID WORKERS	0	0	2,792	0	2,792	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-244,093	0	-244,093	201.00
202.00		TOTAL (sum lines 118-201)	604,868	0	24,691,500	0	24,691,500	202.00

COST ALLOCATION STATISTICS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet Non-CMS W | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,232	61	3,293	3,293	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	44,061	188,804	232,865	418	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	56	6.00
7.00	00700	OPERATION OF PLANT	0	33,779	0	33,779	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,368	2,179	11,547	19	8.00
9.00	00900	HOUSEKEEPING	0	683	2,716	3,399	66	9.00
10.00	01000	DIETARY	0	36,607	4,647	41,254	87	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,349	0	10,349	161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	51,226	0	51,226	0	14.00
15.00	01500	PHARMACY	0	13,869	24,133	38,002	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,958	10,047	30,005	98	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	132,855	59,286	192,141	400	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,052	4,107	17,159	117	31.00
43.00	04300	NURSERY	0	10,416	758	11,174	14	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,224	74,849	120,073	100	50.00
51.00	05100	RECOVERY ROOM	0	4,607	0	4,607	33	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,804	0	19,804	14	52.00
53.00	05300	ANESTHESIOLOGY	0	981	13,462	14,443	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	61,210	885,422	946,632	213	54.00
60.00	06000	LABORATORY	0	23,661	34,670	58,331	263	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	34,904	6,253	41,157	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	44,147	20,172	64,319	71	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	102	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	46,975	10,821	57,796	157	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,045	0	24,045	229	88.00
91.00	09100	EMERGENCY	0	77,551	67,363	144,914	289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	23,661	12,397	36,058	194	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	786,225	1,422,147	2,208,372	3,101	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,876	0	3,876	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	48,033	0	48,033	105	192.00
192.01	19201	WELLNESS CENTER	0	245,243	22,676	267,919	87	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	1,083,377	1,444,823	2,528,200	3,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/21/2013 10:08 pm

		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	233,283					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,333	6,389				6.00
7.00	00700	OPERATION OF PLANT	5,681	208	39,668			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,152	58	371	13,147		8.00
9.00	00900	HOUSEKEEPING	3,606	4	27	646	7,748	9.00
10.00	01000	DIETARY	5,503	226	1,449	0	467	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,857	64	410	0	55	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	784	316	2,027	23	55	14.00
15.00	01500	PHARMACY	0	86	549	0	82	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,130	123	790	0	137	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,596	819	5,258	3,995	2,501	30.00
31.00	03100	INTENSIVE CARE UNIT	5,694	80	517	722	247	31.00
43.00	04300	NURSERY	754	64	412	0	27	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,481	279	1,790	736	934	50.00
51.00	05100	RECOVERY ROOM	1,564	28	182	0	27	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	855	122	784	0	0	52.00
53.00	05300	ANESTHESIOLOGY	602	6	39	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	25,701	377	2,422	1,818	495	54.00
60.00	06000	LABORATORY	23,164	146	936	0	357	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,601	215	1,381	453	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,519	272	1,747	230	192	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,895	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,038	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,082	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	9,154	290	1,859	1,114	550	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,729	148	952	123	0	88.00
91.00	09100	EMERGENCY	16,134	478	3,069	2,689	1,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,121	146	936	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	217,730	4,555	27,907	12,549	7,143	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	42	24	153	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,070	296	1,901	0	0	192.00
192.01	19201	WELLNESS CENTER	8,441	1,514	9,707	598	550	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	55	193.00
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)	233,283	6,389	39,668	13,147	7,748	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	48,986					10.00
11.00	01100	CAFETERIA	38,953	38,953				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	18,896			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	54,431		14.00
15.00	01500	PHARMACY	0	1,316	0	0	40,035	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,711	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,332	7,632	6,272	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	701	1,448	1,541	0	0	31.00
43.00	04300	NURSERY	0	0	205	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,632	1,064	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	334	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	5,396	0	0	0	54.00
60.00	06000	LABORATORY	0	5,132	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	132	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	395	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	51,797	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	2,634	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,132	1,762	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	5,922	3,882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	526	3,836	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,986	37,374	18,896	54,431	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	1,579	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	40,035	201.00
202.00		TOTAL (sum lines 118-201)	48,986	38,953	18,896	54,431	40,035	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,994					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,860		261,806	0	261,806	30.00
31.00	03100	INTENSIVE CARE UNIT	1,932		30,158	0	30,158	31.00
43.00	04300	NURSERY	0		12,650	0	12,650	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,430		139,519	0	139,519	50.00
51.00	05100	RECOVERY ROOM	0		6,775	0	6,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		21,579	0	21,579	52.00
53.00	05300	ANESTHESIOLOGY	0		15,090	0	15,090	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	11,613		994,667	0	994,667	54.00
60.00	06000	LABORATORY	4,129		92,458	0	92,458	60.00
65.00	06500	RESPIRATORY THERAPY	0		0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0		54,939	0	54,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,133		73,878	0	73,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		58,692	0	58,692	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		3,672	0	3,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		21,184	0	21,184	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		77,814	0	77,814	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		36,226	0	36,226	88.00
91.00	09100	EMERGENCY	0		178,394	0	178,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,897		56,714	0	56,714	95.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0		0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0		0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,994	0	2,136,215	0	2,136,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		4,095	0	4,095	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		57,405	0	57,405	192.00
192.01	19201	WELLNESS CENTER	0		290,395	0	290,395	192.01
193.00	19300	NONPAID WORKERS	0		55	0	55	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	40,035	0	40,035	201.00
202.00		TOTAL (sum lines 118-201)	37,994	0	2,528,200	0	2,528,200	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,639					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,418,061				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	336	60	11,219,192			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,581	185,307	1,439,773	-3,534,491	21,440,813	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	190,292	0	582,032	6.00
7.00	00700	OPERATION OF PLANT	3,512	0	0	0	522,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	974	2,139	64,450	0	105,838	8.00
9.00	00900	HOUSEKEEPING	71	2,666	224,663	0	331,447	9.00
10.00	01000	DIETARY	3,806	4,561	295,136	0	505,772	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,076	0	547,515	0	722,134	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,326	0	0	0	72,023	14.00
15.00	01500	PHARMACY	1,442	23,686	0	283,804	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,075	9,861	332,047	0	471,507	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,813	58,188	1,359,974	0	1,984,969	30.00
31.00	03100	INTENSIVE CARE UNIT	1,357	4,031	399,034	0	523,371	31.00
43.00	04300	NURSERY	1,083	744	46,556	0	69,331	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,702	73,463	341,410	0	963,330	50.00
51.00	05100	RECOVERY ROOM	479	0	111,414	0	143,785	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,059	0	47,034	0	78,559	52.00
53.00	05300	ANESTHESIOLOGY	102	13,213	0	0	55,322	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	6,364	869,020	724,635	0	2,361,619	54.00
60.00	06000	LABORATORY	2,460	34,028	896,150	0	2,129,033	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,629	6,137	0	0	1,066,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,590	19,798	240,833	0	415,391	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	633,707	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	95,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	345,857	0	1,937,729	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,884	10,621	534,445	0	841,406	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,500	0	779,426	0	986,085	88.00
91.00	09100	EMERGENCY	8,063	66,115	984,529	0	1,482,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,460	12,167	660,360	0	930,211	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,744	1,395,805	10,565,533	-3,250,687	20,011,340	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	403	0	0	0	3,876	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,994	0	357,874	0	649,810	192.00
192.01	19201	WELLNESS CENTER	25,498	22,256	295,785	0	775,787	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,083,377	1,444,823	2,795,758		3,534,491	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.618134	1.018872	0.249194		0.164849	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,293		233,283	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000294		0.010880	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS	107,722					6.00
7.00	00700	OPERATION OF PLANT	3,512	104,210				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	974	974	8,687			8.00
9.00	00900	HOUSEKEEPING	71	71	427	282		9.00
10.00	01000	DIETARY	3,806	3,806	0	17	56,090	10.00
11.00	01100	CAFETERIA	0	0	0	0	44,602	11.00
13.00	01300	NURSING ADMINISTRATION	1,076	1,076	0	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,326	5,326	15	2	0	14.00
15.00	01500	PHARMACY	1,442	1,442	0	3	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,075	2,075	0	5	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,813	13,813	2,641	91	10,685	30.00
31.00	03100	INTENSIVE CARE UNIT	1,357	1,357	477	9	803	31.00
43.00	04300	NURSERY	1,083	1,083	0	1	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,702	4,702	486	34	0	50.00
51.00	05100	RECOVERY ROOM	479	479	0	1	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,059	2,059	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	102	102	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	6,364	6,364	1,201	18	0	54.00
60.00	06000	LABORATORY	2,460	2,460	0	13	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,629	3,629	299	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,590	4,590	152	7	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,884	4,884	736	20	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,500	2,500	81	0	0	88.00
91.00	09100	EMERGENCY	8,063	8,063	1,777	37	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,460	2,460	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,827	73,315	8,292	260	56,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	403	403	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,994	4,994	0	0	0	192.00
192.01	19201	WELLNESS CENTER	25,498	25,498	395	20	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	2	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	677,979	630,331	135,306	393,613	659,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.293784	6.048661	15.575688	1,395.790780	11.764147	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,389	39,668	13,147	7,748	48,986	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.059310	0.380654	1.513411	27.475177	0.873346	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		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						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	296					11.00
13.00	01300	NURSING ADMINISTRATION	0	196,821				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	665,934			14.00
15.00	01500	PHARMACY	10	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	0	0	0	14,749	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58	65,319	0	0	4,604	30.00
31.00	03100	INTENSIVE CARE UNIT	11	16,054	0	0	750	31.00
43.00	04300	NURSERY	0	2,137	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20	11,087	0	0	555	50.00
51.00	05100	RECOVERY ROOM	0	3,477	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	41	0	0	0	4,508	54.00
60.00	06000	LABORATORY	39	0	0	0	1,603	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3	0	0	0	828	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	633,707	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	32,227	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	39	18,357	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	45	40,437	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4	39,953	0	0	1,901	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	284	196,821	665,934	100	14,749	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	WELLNESS CENTER	12	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	524,704	857,249	152,658	-244,093	604,868	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,772.648649	4.355475	0.229239	0.000000	41.010780	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,953	18,896	54,431	40,035	37,994	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	131.597973	0.096006	0.081736	400.350000	2.576039	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/21/2013 10:08 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		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		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
		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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
99.00	09900	CMHC	0	99.00
99.10	09910	CORF	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
106.00	10600	HEART ACQUISITION	0	106.00
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW - SNF		114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	WELLNESS CENTER	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,352,649		3,352,649	0	3,352,649	30.00
31.00	03100	INTENSIVE CARE UNIT	776,016		776,016	0	776,016	31.00
43.00	04300	NURSERY	104,831		104,831	0	104,831	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,341,698		1,341,698	0	1,341,698	50.00
51.00	05100	RECOVERY ROOM	189,940		189,940	0	189,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	116,922		116,922	0	116,922	52.00
53.00	05300	ANESTHESIOLOGY	65,701		65,701	0	65,701	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,130,859		3,130,859	0	3,130,859	54.00
60.00	06000	LABORATORY	2,663,383		2,663,383	0	2,663,383	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,293,306	0	1,293,306	0	1,293,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	591,933		591,933	0	591,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	883,443		883,443	0	883,443	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	118,491		118,491	0	118,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,257,162		2,257,162	0	2,257,162	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,228,858		1,228,858	0	1,228,858	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,180,758		1,180,758	0	1,180,758	88.00
91.00	09100	EMERGENCY	2,162,087		2,162,087	0	2,162,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,472		267,472		267,472	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,372,984		1,372,984	0	1,372,984	95.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0		0		0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (see instructions)	23,098,493	0	23,098,493	0	23,098,493	200.00
201.00		Less Observation Beds	267,472		267,472		267,472	201.00
202.00		Total (see instructions)	22,831,021	0	22,831,021	0	22,831,021	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,931,528		1,931,528			30.00
31.00	03100	INTENSIVE CARE UNIT	330,418		330,418			31.00
43.00	04300	NURSERY	103,759		103,759			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	770,674	2,851,818	3,622,492	0.370380	0.000000	50.00
51.00	05100	RECOVERY ROOM	45,608	143,608	189,216	1.003826	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	199,588	80,888	280,476	0.416870	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	308,384	1,919,653	2,228,037	0.029488	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,205,986	11,812,451	13,018,437	0.240494	0.000000	54.00
60.00	06000	LABORATORY	5,939,505	8,065,278	14,004,783	0.190177	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	227,972	4,043,769	4,271,741	0.302759	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	377,711	961,814	1,339,525	0.441898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,632	345,267	461,899	1.912632	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,292	136,984	151,276	0.783277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,056,769	1,671,304	2,728,073	0.827383	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	122,199	2,377,626	2,499,825	0.491578	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	815,655	815,655			88.00
91.00	09100	EMERGENCY	547,335	4,169,559	4,716,894	0.458371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	47,705	142,220	189,925	1.408303	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,618,921	1,618,921	0.848086	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0			106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (see instructions)	13,346,065	41,156,815	54,502,880			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,346,065	41,156,815	54,502,880			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.370380	50.00
51.00	05100	RECOVERY ROOM	1.003826	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.416870	52.00
53.00	05300	ANESTHESIOLOGY	0.029488	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.240494	54.00
60.00	06000	LABORATORY	0.190177	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.302759	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.441898	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.912632	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.783277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.827383	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.491578	75.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.458371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.408303	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.848086	95.00
99.00	09900	CMHC		99.00
99.10	09910	CORF		99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.		100.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
106.00	10600	HEART ACQUISITION		106.00
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW - SNF		114.00
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: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,352,649		3,352,649	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	776,016		776,016	0	0	31.00
43.00	04300	NURSERY	104,831		104,831	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,341,698		1,341,698	0	0	50.00
51.00	05100	RECOVERY ROOM	189,940		189,940	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	116,922		116,922	0	0	52.00
53.00	05300	ANESTHESIOLOGY	65,701		65,701	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,130,859		3,130,859	0	0	54.00
60.00	06000	LABORATORY	2,663,383		2,663,383	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,293,306	0	1,293,306	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	591,933		591,933	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	883,443		883,443	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	118,491		118,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,257,162		2,257,162	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,228,858		1,228,858	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,180,758		1,180,758	0	0	88.00
91.00	09100	EMERGENCY	2,162,087		2,162,087	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,472		267,472		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,372,984		1,372,984	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0		0		0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (see instructions)	23,098,493	0	23,098,493	0	0	200.00
201.00		Less Observation Beds	267,472		267,472		0	201.00
202.00		Total (see instructions)	22,831,021	0	22,831,021	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,931,528		1,931,528			30.00
31.00	03100	INTENSIVE CARE UNIT	330,418		330,418			31.00
43.00	04300	NURSERY	103,759		103,759			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	770,674	2,851,818	3,622,492	0.370380	0.000000	50.00
51.00	05100	RECOVERY ROOM	45,608	143,608	189,216	1.003826	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	199,588	80,888	280,476	0.416870	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	308,384	1,919,653	2,228,037	0.029488	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,205,986	11,812,451	13,018,437	0.240494	0.000000	54.00
60.00	06000	LABORATORY	5,939,505	8,065,278	14,004,783	0.190177	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	227,972	4,043,769	4,271,741	0.302759	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	377,711	961,814	1,339,525	0.441898	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,632	345,267	461,899	1.912632	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,292	136,984	151,276	0.783277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,056,769	1,671,304	2,728,073	0.827383	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	122,199	2,377,626	2,499,825	0.491578	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	815,655	815,655	1.447619	0.000000	88.00
91.00	09100	EMERGENCY	547,335	4,169,559	4,716,894	0.458371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	47,705	142,220	189,925	1.408303	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,618,921	1,618,921	0.848086	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0			106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (see instructions)	13,346,065	41,156,815	54,502,880			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,346,065	41,156,815	54,502,880			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
106.00	10600	HEART ACQUISITION			106.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW - SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part II Date/Time Prepared: 11/21/2013 10:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,341,698	139,519	1,202,179	13,952	0	50.00
51.00	05100	RECOVERY ROOM	189,940	6,775	183,165	678	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	116,922	21,579	95,343	2,158	0	52.00
53.00	05300	ANESTHESIOLOGY	65,701	15,090	50,611	1,509	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,130,859	994,667	2,136,192	99,467	0	54.00
60.00	06000	LABORATORY	2,663,383	92,458	2,570,925	9,246	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,293,306	54,939	1,238,367	5,494	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	591,933	73,878	518,055	7,388	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	883,443	58,692	824,751	5,869	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	118,491	3,672	114,819	367	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,257,162	21,184	2,235,978	2,118	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,228,858	77,814	1,151,044	7,781	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,180,758	36,226	1,144,532	3,623	0	88.00
91.00	09100	EMERGENCY	2,162,087	178,394	1,983,693	17,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,472	20,975	246,497	2,098	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,372,984	56,714	1,316,270	5,671	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	18,864,997	1,852,576	17,012,421	185,258	0	200.00
201.00		Less Observation Beds	267,472	20,975	246,497	2,098	0	201.00
202.00		Total (line 200 minus line 201)	18,597,525	1,831,601	16,765,924	183,160	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part II | Date/Time Prepared: 11/21/2013 10:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,327,746	3,622,492	0.366528		50.00
51.00	05100	RECOVERY ROOM	189,262	189,216	1.000243		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	114,764	280,476	0.409176		52.00
53.00	05300	ANESTHESIOLOGY	64,192	2,228,037	0.028811		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,031,392	13,018,437	0.232854		54.00
60.00	06000	LABORATORY	2,654,137	14,004,783	0.189516		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,287,812	4,271,741	0.301472		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	584,545	1,339,525	0.436382		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	877,574	461,899	1.899926		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	118,124	151,276	0.780851		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,255,044	2,728,073	0.826607		73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,221,077	2,499,825	0.488465		75.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,177,135	815,655	1.443178		88.00
91.00	09100	EMERGENCY	2,144,248	4,716,894	0.454589		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	265,374	189,925	1.397257		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,367,313	1,618,921	0.844583		95.00
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
100.00	10000	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0.000000		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
106.00	10600	HEART ACQUISITION	0	0	0.000000		106.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (sum of lines 50 thru 199)	18,679,739	52,137,175			200.00
201.00		Less Observation Beds	265,374	0			201.00
202.00		Total (line 200 minus line 201)	18,414,365	52,137,175			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part I Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	261,806	1,099	260,707	3,470	75.13	30.00
31.00	INTENSIVE CARE UNIT	30,158		30,158	253	119.20	31.00
43.00	NURSERY	12,650		12,650	212	59.67	43.00
200.00	Total (lines 30-199)	304,614		303,515	3,935		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,356	177,006				30.00
31.00	INTENSIVE CARE UNIT	171	20,383				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	2,527	197,389				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,519	3,622,492	0.038515	297,198	11,447	50.00
51.00	05100	RECOVERY ROOM	6,775	189,216	0.035806	15,565	557	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,579	280,476	0.076937	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,090	2,228,037	0.006773	110,579	749	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	994,667	13,018,437	0.076404	1,120,114	85,581	54.00
60.00	06000	LABORATORY	92,458	14,004,783	0.006602	2,144,525	14,158	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	54,939	4,271,741	0.012861	184,712	2,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	73,878	1,339,525	0.055152	375,250	20,696	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,692	461,899	0.127067	66,185	8,410	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,672	151,276	0.024274	6,812	165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,184	2,728,073	0.007765	890,552	6,915	73.00
75.00	07500	ASC (NON-DISTINCT PART)	77,814	2,499,825	0.031128	82,080	2,555	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,226	815,655	0.044413	0	0	88.00
91.00	09100	EMERGENCY	178,394	4,716,894	0.037820	542,189	20,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,975	189,925	0.110438	36,088	3,985	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,795,862	50,518,254		5,871,849	178,100	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part III Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,470	0.00	2,356	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	253	0.00	171	0	0	31.00
43.00	04300	NURSERY	212	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	3,935		2,527	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,622,492	0.000000	0.000000	297,198	50.00
51.00	05100	RECOVERY ROOM	0	189,216	0.000000	0.000000	15,565	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	280,476	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,228,037	0.000000	0.000000	110,579	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	13,018,437	0.000000	0.000000	1,120,114	54.00
60.00	06000	LABORATORY	0	14,004,783	0.000000	0.000000	2,144,525	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,271,741	0.000000	0.000000	184,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,339,525	0.000000	0.000000	375,250	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	461,899	0.000000	0.000000	66,185	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	151,276	0.000000	0.000000	6,812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,728,073	0.000000	0.000000	890,552	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,499,825	0.000000	0.000000	82,080	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	815,655	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	4,716,894	0.000000	0.000000	542,189	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	189,925	0.000000	0.000000	36,088	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	50,518,254			5,871,849	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,103,517	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	139,357	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	521,048	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	4,266,692	0	0	0	54.00
60.00	06000	LABORATORY	0	369,583	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,368	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	592,290	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	117,651	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	132,635	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,281,644	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	960,592	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	1,238,290	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	127,136	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,852,803	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.370380	1,103,517	0	0	408,721	50.00
51.00	05100	RECOVERY ROOM	1.003826	139,357	0	0	139,890	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.416870	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029488	521,048	0	0	15,365	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.240494	4,266,692	0	0	1,026,114	54.00
60.00	06000	LABORATORY	0.190177	369,583	6,175	0	70,286	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.302759	2,368	0	0	717	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.441898	592,290	0	0	261,732	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.912632	117,651	0	0	225,023	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.783277	132,635	0	0	103,890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.827383	1,281,644	0	596	1,060,410	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.491578	960,592	0	0	472,206	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.458371	1,238,290	0	0	567,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.408303	127,136	0	0	179,046	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.848086		0			95.00
200.00		Subtotal (see instructions)		10,852,803	6,175	596	4,530,996	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		10,852,803	6,175	596	4,530,996	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	1,174	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	493		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,174	493		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,174	493		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,542	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,470	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,192	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	36	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)	36	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)	2,356	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)	36	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)	36	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	192.90	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	197.90	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,352,649	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)	6,944	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)	7,124	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)	14,068	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,338,581	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,338,581	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)	962.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,266,778	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)	2,266,778	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/21/2013 10:08 pm

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	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	776,016	253	3,067.26	171	524,501	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)	2,236,375	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,027,654	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)	197,389	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	178,100	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	375,489	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,652,165	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)	6,944	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	7,124	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	14,068	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)	278	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	962.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	267,472	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/21/2013 10:08 pm

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	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	261,806	3,338,581	0.078418	267,472	20,975	90.00
91.00	Nursing School cost	0	3,338,581	0.000000	267,472	0	91.00
92.00	Allied health cost	0	3,338,581	0.000000	267,472	0	92.00
93.00	All other Medical Education	0	3,338,581	0.000000	267,472	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/21/2013 10:08 pm

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		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		1,246,370		30.00
31.00	03100	INTENSIVE CARE UNIT		217,451		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.370380	297,198	110,076	50.00
51.00	05100	RECOVERY ROOM	1.003826	15,565	15,625	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.416870	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029488	110,579	3,261	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.240494	1,120,114	269,381	54.00
60.00	06000	LABORATORY	0.190177	2,144,525	407,839	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.302759	184,712	55,923	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.441898	375,250	165,822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.912632	66,185	126,588	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.783277	6,812	5,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.827383	890,552	736,828	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.491578	82,080	40,349	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.458371	542,189	248,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.408303	36,088	50,823	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,871,849	2,236,375	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,871,849		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3

Component CCN: 14U059 | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Swing Beds - SNF | 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	0.370380	0	0	50.00
51.00	05100	RECOVERY ROOM	1.003826	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.416870	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029488	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.240494	420	101	54.00
60.00	06000	LABORATORY	0.190177	10,630	2,022	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.302759	22,343	6,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.441898	169	75	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.912632	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.783277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.827383	16,049	13,279	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.491578	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.458371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.408303	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		49,611	22,242	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)		49,611		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1	
		0	1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		3,495,384		1.00
2.00	Outlier payments for discharges. (see instructions)		16,243		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		44.04		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.22		30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.52		31.00
32.00	Sum of lines 30 and 31		16.74		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.63		33.00
34.00	Disproportionate share adjustment (see instructions)		126,882		34.00
	Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Date/Time Prepared: 11/21/2013 10:08 pm

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			before 1/1	on/after 1/1	
		0	1.00	1.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		3,638,509		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		4,073,123		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		3,964,470		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		275,991		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,240,461		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,240,461		61.00
62.00	Deductibles billed to program beneficiaries		585,652		62.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		145,109		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		101,576		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		106,890		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,756,385		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00			0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-5,713		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-5,612		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2012	152,202		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	451,494		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,348,756		71.00
71.01	Sequestration adjustment (see instructions)		21,744		71.01
72.00	Interim payments		4,345,139		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-18,127		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		437,484		75.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140059	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/21/2013 10:08 pm
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			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/21/2013 10:08 pm

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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.22	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	13.52	0.00			13.52	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	16.74	0.00			13.52	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	44.04	0.00			44.04	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	3.63	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	439	0			439	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	58	0			58	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	0	0			0	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	497	0			497	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	3,729	0			3,729	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	18	0			18	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	72	0			72	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	3,675	0			3,675	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	13.52	0.00			13.52	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/21/2013 10:08 pm

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.63		0.00	True	29.00
30.00	Line 28 or 29 as applicable		3.63		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet DSH | Date/Time Prepared: 11/21/2013 10:08 pm

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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.46		29.00
30.00	Line 28 or 29 as applicable	3.46		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/21/2013 10:08 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	3,495,384	0	873,846	2,621,538	1.00
2.00	Outlier payments for discharges (see instructions)	2.00	16,243	0	4,061	12,182	2.00
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0363	0.0363	0.0363	0.0363	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	126,882	0	31,721	95,161	11.00
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,638,509	0	909,628	2,728,881	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	4,073,123	0	1,018,281	3,054,842	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	3,964,470	0	991,118	2,973,352	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	275,991	0	68,998	206,993	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,060,116	3,180,345	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	275,467	0	68,867	206,600	20.00
21.00	Capital DRG outlier payments	2.00	524	0	131	393	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	275,991	0	68,998	206,993	26.00
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.143571	0.141964	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			152,202		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				451,494	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/21/2013 10:08 pm

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		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	3,495,384		1.00
2.00	Outlier payments for discharges (see instructions)	16,243		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	126,882		11.00
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	3,638,509		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	4,073,123		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	3,964,470		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	275,991		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	4,240,461		19.00
		5.00		
20.00	Capital DRG other than outlier	275,467		20.00
21.00	Capital DRG outlier payments	524		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	275,991		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	152,202		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	451,494		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140059	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/21/2013 10:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,667	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,530,996	2.00
3.00	PPS payments	3,300,990	3.00
4.00	Outlier payment (see instructions)	4,803	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,667	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,771	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)	6,771	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	6,771	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,104	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,667	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,305,793	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)	821,286	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)	2,486,174	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)	2,486,174	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,486,174	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)	164,997	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	115,498	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	126,828	36.00
37.00	Subtotal (see instructions)	2,601,672	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,601,672	40.00
40.01	Sequestration adjustment (see instructions)	13,008	40.01
41.00	Interim payments	2,624,297	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-35,633	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,302,473		2,581,231	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	04/23/2013	66,995	01/25/2013	42,712	3.01
3.02			0	04/23/2013	354	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	01/25/2013	24,329		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)		42,666		43,066	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)		4,345,139		2,624,297	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		3,617		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		22,625	6.02
7.00	Total Medicare program liability (see instructions)		4,348,756		2,601,672	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: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2013 10:08 pm

Component CCN: 14U059 | Title XVIII | Swing Beds - SNF | 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		17,769		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)		17,769		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		68		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		17,837		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: 140059	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/21/2013 10:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,143	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,527	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	67	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,445	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	54,502,880	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	242,405	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,134,450	8.00
9.00	Sequestration adjustment amount (see instructions)	22,689	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,111,761	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	957,971	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)	153,790	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140059 | Component CCN: 14U059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-2 | Date/Time Prepared: 11/21/2013 10:08 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	18,271	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	72	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	18,271	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	18,271	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	18,271	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	434	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	17,837	0	15.00
16.00		0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	17,837	0	19.00
19.01	Sequestration adjustment (see instructions)	89	0	19.01
20.00	Interim payments	17,769	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-21	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 11/21/2013 10:08 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	268,066	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	11,324,998	0	0	0	4.00
5.00	Other receivable	493,399	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,698,796	0	0	0	6.00
7.00	Inventory	446,130	0	0	0	7.00
8.00	Prepaid expenses	162,911	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,996,708	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	55,000	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	19,205,382	0	0	0	15.00
16.00	Accumulated depreciation	-8,155,224	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	13,963,106	0	0	0	23.00
24.00	Accumulated depreciation	-9,632,742	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)	15,435,522	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,158,146	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	131,789	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,289,935	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,722,165	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,532,269	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,105,394	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	430,091	0	0	0	40.00
41.00	Deferred income	65,058	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,132,812	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,998,187	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	6,998,187	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	10,130,999	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,591,166				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,591,166	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,722,165	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 11/21/2013 10:08 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,629,528		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,038,357				2.00
3.00	Total (sum of line 1 and line 2)		14,591,171		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		14,591,171		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	IMMATERIAL VARIANCE	5		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,591,166		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	IMMATERIAL VARIANCE		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: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2013 10:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,121,453		2,121,453	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				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,121,453		2,121,453	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	330,418		330,418	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)	330,418		330,418	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,451,871		2,451,871	17.00
18.00	Ancillary services	6,265,860	40,376,111	46,641,971	18.00
19.00	Outpatient services	645,137	7,481,137	8,126,274	19.00
20.00	RURAL HEALTH CLINIC	0	815,655	815,655	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	1,625,039	1,625,039	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	104,784	0	104,784	27.00
27.01	PHYSICIANS PRIVATE OFFICES	0	177,787	177,787	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,467,652	50,475,729	59,943,381	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,862,866		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,862,866		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140059 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 11/21/2013 10:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	59,943,381	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,756,902	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,186,479	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,862,866	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,676,387	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	613,975	6.00
7.00	Income from investments	64,605	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	26,954	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	126,827	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	12,781	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	448	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	WELLNESS CENTER	567,910	24.00
24.01	MISC REVENUE	1,019,511	24.01
24.02	GRANT REVENUE	1,207,022	24.02
25.00	Total other income (sum of lines 6-24)	3,640,033	25.00
26.00	Total (line 5 plus line 25)	-1,036,354	26.00
27.00	GAIN ON SALE OF ASSETS	2,003	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,003	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,038,357	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140059	Period: From 07/01/2012 To 06/30/2013	Worksheet L Parts I-III Date/Time Prepared: 11/21/2013 10:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	275,467	1.00
2.00	Capital DRG outlier payments	524	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	9.49	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	275,991	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140059 Component CCN: 148509 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/21/2013 10:08 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	779,426	0	779,426	0	779,426	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	779,426	0	779,426	0	779,426	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	1,144	1,144	0	1,144	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	161,127	161,127	0	161,127	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	162,271	162,271	0	162,271	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	779,426	162,271	941,697	0	941,697	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	779,426	162,271	941,697	0	941,697	32.00

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

Provider CCN: 140059 | Component CCN: 148509 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/21/2013 10:08 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-173,885	605,541		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	-173,885	605,541		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	1,144		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	161,127		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	162,271		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-173,885	767,812		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-173,885	767,812		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140059 | Component CCN: 148509 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-2 | Date/Time Prepared: 11/21/2013 10:08 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.96	3,294	4,200	4,032		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.96	3,294		4,032	4,032	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.96	3,294			4,032	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)					767,812	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)					767,812	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)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					412,946	15.00
16.00	Total overhead (sum of lines 14 and 15)					412,946	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					412,946	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					412,946	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,180,758	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140059 Component CCN: 148509	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3 Date/Time Prepared: 11/21/2013 10:08 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,180,758	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)		1,180,758	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,032	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,032	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		292.85	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	292.85	292.85	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	94	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	27,528	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) *		27,528	16.00
16.01	Total program charges (see instructions)(from contractor's records)		14,054	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		884	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,732	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.)		20,363	16.04
16.05	Total program cost (see instructions)		22,095	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		342	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,566	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		22,095	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)		22,095	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			0	25.00
26.00	Net reimbursable amount (see instructions)		22,095	26.00
26.01	Sequestration adjustment (see instructions)		110	26.01
27.00	Interim payments		15,999	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		5,986	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

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

Provider CCN: 140059 Component CCN: 148509

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

Worksheet M-5

Date/Time Prepared: 11/21/2013 10:08 pm

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		9,109	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		01/25/2013	6,890	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)		6,890	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		15,999	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		6,096	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		22,095	7.00

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