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: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/29/2013 11:06 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2013 Time: 11:06 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (141305) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	108,774	111,240	432,174	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	73,895	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		34,076		0	10.00
200.00	Total	0	182,669	145,316	432,174	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: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2013 9:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	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	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	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	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				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)				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: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2013 9:56 am

		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: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00

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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)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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.	Y	Y	Y	N	109.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	237,949	0	0	118.01

		V	XIX	
		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)	Y		140.00

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

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

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

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

		1.00	
	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)	505,585	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2012	09/30/2012	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2013 9:56 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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	01/01/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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)		Y	10/16/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2013 9:56 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2013 9:56 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/16/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CHIEF FINANCIAL OFFICER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 11/29/2013 9:56 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	40,608.00	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)		18	6,570	40,608.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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)		18	6,570	40,608.00	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	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		18				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: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2013 9:56 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,025	240	1,601			1.00
2.00	HMO and other (see instructions)	9	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	775	0	785			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	38			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,800	240	2,424			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		96	250			13.00
14.00	Total (see instructions)	1,800	336	2,674	0.00	140.40	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			0	0.00	10.76	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	1,336	0	9,732	0.00	12.80	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	163.96	27.00
28.00	Observation Bed Days		0	349			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	91			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-3 Part I Date/Time Prepared: 11/29/2013 9:56 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	288	100	527	1.00
2.00	HMO and other (see instructions)			4			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	288	100	527	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	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 11/29/2013 9:56 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street		1.00
		City: 1.00	State: 2.00	Zip Code: 3.00
2.00	City, State, Zip Code, County		IL		2.00
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award: 1.00	Date: 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
9.01			0		9.01
9.02			0		9.02
9.03			0		9.03
9.04			0		9.04
9.05			0		9.05
9.06			0		9.06
9.07			0		9.07
9.08			0		9.08
9.09			0		9.09
9.10			0		9.10
			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: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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.			Y	2	13.00

		Provider name: 1.00	CCN number: 2.00	
14.00	Provider name, CCN number	BOWEN CLINIC	143456	14.00
14.01		ADAMS STREET CLINIC	143405	14.01

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

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-8 | Date/Time Prepared: 11/29/2013 9:56 am

Rural Health Clinic (RHC) I | Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		HANCOCK				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	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet S-10 | Date/Time Prepared: 11/29/2013 9:56 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.582493	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,453,603	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	914,988	5.00
6.00	Medicaid charges	7,428,054	6.00
7.00	Medicaid cost (line 1 times line 6)	4,326,789	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,958,198	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	178,055	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,958,198	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	354,497	69,404	423,901	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	206,492	40,427	246,919	21.00
22.00	Partial payment by patients approved for charity care	6,683	17,129	23,812	22.00
23.00	Cost of charity care (line 21 minus line 22)	199,809	23,298	223,107	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)	602,308	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	294,148	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	308,160	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	179,501	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	402,608	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,360,806	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,183,693	1,183,693	-1,162,891	20,802	1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG		100,746	100,746	-14,301	86,445	1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	2,317,020	2,317,020	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		781,285	781,285	29,940	811,225	2.00
2.01	00201	NEW CAP REL COSTS-NH ME		0	0	7,905	7,905	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,883,412	1,883,412	-47,430	1,835,982	4.00
4.01	00401	SHARED HUMAN RESOURCES	77,175	14,544	91,719	0	91,719	4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	365,758	1,145,911	1,511,669	134,847	1,646,516	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	907,306	293,466	1,200,772	0	1,200,772	5.02
7.00	00700	OPERATION OF PLANT	132,411	503,116	635,527	0	635,527	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	9,360	128,833	138,193	0	138,193	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,565	49,565	0	49,565	8.00
9.00	00900	HOUSEKEEPING	105,151	37,131	142,282	0	142,282	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	20,800	1,586	22,386	0	22,386	9.01
10.00	01000	DIETARY	148,703	87,712	236,415	-105,598	130,817	10.00
11.00	01100	CAFETERIA	0	0	0	105,598	105,598	11.00
13.00	01300	NURSING ADMINISTRATION	122,813	63,308	186,121	-38,204	147,917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	135,179	51,828	187,007	9,700	196,707	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	38,204	38,204	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	372,896	17,969	390,865	0	390,865	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	929,427	30,041	959,468	147,793	1,107,261	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,825	3,825	171,131	174,956	43.00
46.00	04600	OTHER LONG TERM CARE	0	34,993	34,993	0	34,993	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	330,703	42,714	373,417	0	373,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	333,956	75,086	409,042	-318,924	90,118	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,980	591,937	1,011,917	0	1,011,917	54.00
56.00	05600	RADIOISOTOPE	0	77,790	77,790	0	77,790	56.00
60.00	06000	LABORATORY	436,687	682,355	1,119,042	0	1,119,042	60.00
60.02	06002	GEO PSYCH	75,427	173,497	248,924	0	248,924	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,465	45,465	0	45,465	62.00
65.00	06500	RESPIRATORY THERAPY	164,834	45,870	210,704	-5,828	204,876	65.00
66.00	06600	PHYSICAL THERAPY	0	80,314	80,314	0	80,314	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,039	5,039	5,828	10,867	69.00
69.01	06901	PULMONARY REHAB	36,185	130,113	166,298	0	166,298	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,423	500,409	535,832	-91,108	444,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	91,108	91,108	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,540	481,323	616,863	0	616,863	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	842,938	380,258	1,223,196	-92,405	1,130,791	88.00
90.00	09000	CLINIC	1,360,299	292,467	1,652,766	-79,305	1,573,461	90.00
91.00	09100	EMERGENCY	350,218	1,425,334	1,775,552	1,343	1,776,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	52,802	6,563	59,365	0	59,365	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,211,072	1,211,072	-1,211,072	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,901,971	12,660,570	20,562,541	-106,649	20,455,892	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	118,333	93,027	211,360	100,253	311,613	192.00
194.00	07950	NAUVOO APARTMENTS	0	14,855	14,855	6,396	21,251	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	8,020,304	12,768,452	20,788,756	0	20,788,756	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	20,802		1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	0	86,445		1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-20,948	2,296,072		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-243,169	568,056		2.00
2.01	00201	NEW CAP REL COSTS-NH ME	0	7,905		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-62,021	1,773,961		4.00
4.01	00401	SHARED HUMAN RESOURCES	0	91,719		4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	-386,544	1,259,972		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,050	1,199,722		5.02
7.00	00700	OPERATION OF PLANT	-80,736	554,791		7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	138,193		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,565		8.00
9.00	00900	HOUSEKEEPING	0	142,282		9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	22,386		9.01
10.00	01000	DIETARY	-1,932	128,885		10.00
11.00	01100	CAFETERIA	-29,144	76,454		11.00
13.00	01300	NURSING ADMINISTRATION	0	147,917		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,632	193,075		16.00
17.00	01700	SOCIAL SERVICE	0	38,204		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	390,865		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,107,261		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	174,956		43.00
46.00	04600	OTHER LONG TERM CARE	-34,993	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	373,417		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	90,118		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,893	1,010,024		54.00
56.00	05600	RADIOISOTOPE	0	77,790		56.00
60.00	06000	LABORATORY	-1,525	1,117,517		60.00
60.02	06002	GEO PSYCH	-27,082	221,842		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	45,465		62.00
65.00	06500	RESPIRATORY THERAPY	-510	204,366		65.00
66.00	06600	PHYSICAL THERAPY	0	80,314		66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,867		69.00
69.01	06901	PULMONARY REHAB	0	166,298		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,295	441,429		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	91,108		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	616,863		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-20,322	1,110,469		88.00
90.00	09000	CLINIC	-1,175,649	397,812		90.00
91.00	09100	EMERGENCY	-261,363	1,515,532		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	59,365		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,355,808	18,100,084		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	311,613		192.00
194.00	07950	NAUVOO APARTMENTS	0	21,251		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-2,355,808	18,432,948		200.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/29/2013 9:56 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS DEPRECIATION EXPENSE				
1.00	NEW CAP REL COSTS-NH ME	2.01	0	7,905	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,160,331	2.00
3.00	NAUVOO APARTMENTS	194.00	0	6,396	3.00
	TOTALS		0	1,174,632	
	B - TO RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	66,420	39,178	1.00
	TOTALS		66,420	39,178	
	C - TO RECLASS RHC DEPR EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	2,560	1.00
	TOTALS		0	2,560	
	D - TO RECLASS SOCIAL SERVICES SALARY				
1.00	SOCIAL SERVICE	17.00	38,204	0	1.00
	TOTALS		38,204	0	
	E - TO RECLASS INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	29,940	1.00
2.00	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	24,443	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,156,689	3.00
	TOTALS		0	1,211,072	
	F - TO RECLASS ACUTE AND NURSERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	112,472	35,321	1.00
2.00	NURSERY	43.00	145,083	26,048	2.00
	TOTALS		257,555	61,369	
	G - TO RECLASS BILLING AND TRANSCRIPTION				
1.00	HOSPITAL ONLY BUS OFF AND A&G	5.01	110,404	0	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,700	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		110,404	9,700	
	H - TO RECLASS EKG TIME				
1.00	ELECTROCARDIOLOGY	69.00	8,501	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	2,673	2.00
	TOTALS		8,501	2,673	
	I - TO RECLASS RHC TIME STUDY				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	110,289	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	46,243	0	2.00
	TOTALS		156,532	0	
	K - RECLASS ALLOWABLE PHYSICIAN FICA				
1.00	CLINIC	90.00	0	46,087	1.00
2.00	EMERGENCY	91.00	0	1,343	2.00
	TOTALS		0	47,430	
	M - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	91,108	1.00
	TOTALS		0	91,108	
500.00	Grand Total: Increases		637,616	2,639,722	500.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-6 | Date/Time Prepared: 11/29/2013 9:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-NH BLDG	1.01	0	7,905	9		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,160,331	9		2.00
3.00	NEW CAP REL COSTS-NH BLDG	1.01	0	6,396	9		3.00
	TOTALS		0	1,174,632			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	66,420	39,178	0		1.00
	TOTALS		66,420	39,178			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,560	9		1.00
	TOTALS		0	2,560			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	NURSING ADMINISTRATION	13.00	38,204	0	0		1.00
	TOTALS		38,204	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,211,072	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,211,072			
	F - TO RECLASS ACUTE AND NURSERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	112,472	35,321	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	145,083	26,048	0		2.00
	TOTALS		257,555	61,369			
	G - TO RECLASS BILLING AND TRANSCRIPTION						
1.00	CLINIC	90.00	0	9,700	0		1.00
2.00	CLINIC	90.00	58,766	0	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	41,602	0	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	10,036	0	0		4.00
	TOTALS		110,404	9,700			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	8,501	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	2,673	0		2.00
	TOTALS		8,501	2,673			
	I - TO RECLASS RHC TIME STUDY						
1.00	RURAL HEALTH CLINIC	88.00	99,606	0	0		1.00
2.00	CLINIC	90.00	56,926	0	0		2.00
	TOTALS		156,532	0			
	K - RECLASS ALLOWABLE PHYSICIAN FICA						
1.00	EMPLOYEE BENEFITS	4.00	0	47,430	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	47,430			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	91,108	0		1.00
	TOTALS		0	91,108			
500.00	Grand Total: Decreases		637,616	2,639,722			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	521,757	0	0	0	0	1.00
2.00	Land Improvements	347,356	0	0	0	501	2.00
3.00	Buildings and Fixtures	26,265,434	296,716	0	296,716	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,557,955	300,911	0	300,911	53,091	6.00
7.00	HIT designated Assets	1,331,937	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,024,439	597,627	0	597,627	53,592	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,024,439	597,627	0	597,627	53,592	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	521,757	0	1.00
2.00	Land Improvements	346,855	0	2.00
3.00	Buildings and Fixtures	26,562,150	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	2,805,775	0	6.00
7.00	HIT designated Assets	1,331,937	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,568,474	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,568,474	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2013 9:56 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,183,693	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	100,746	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	781,285	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,065,724	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,183,693		1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	100,746		1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	781,285		2.00
2.01	NEW CAP REL COSTS-NH ME	0	0		2.01
3.00	Total (sum of lines 1-2)	0	2,065,724		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-7 Part III Date/Time Prepared: 11/29/2013 9:56 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	347,356	0	347,356	0.011388	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	3,104,269	0	3,104,269	0.101770	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	23,161,165	0	23,161,165	0.759316	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,857,004	0	3,857,004	0.126448	0	2.00
2.01	NEW CAP REL COSTS-NH ME	32,888	0	32,888	0.001078	0	2.01
3.00	Total (sum of lines 1-2)	30,502,682	0	30,502,682	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	20,802	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	86,445	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,158,156	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	538,116	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	7,905	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,811,424	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	20,802	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	0	86,445	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,137,916	0	0	0	2,296,072	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	29,940	0	0	0	568,056	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	7,905	2.01
3.00	Total (sum of lines 1-2)	1,167,856	0	0	0	2,979,280	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/29/2013 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-NH BLDG (chapter 2)		0	NEW CAP REL COSTS-NH BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-NH ME (chapter 2)		0	NEW CAP REL COSTS-NH ME	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-2,175	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,258	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,369,213			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	-83,067			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-29,144	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,632	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,932	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	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-NH BLDG		0	NEW CAP REL COSTS-NH BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8 | Date/Time Prepared: 11/29/2013 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.01	Depreciation - NEW CAP REL COSTS-NH ME		0	NEW CAP REL COSTS-NH ME	2.01	0	27.01
28.00	Non-physician Anesthetist		0	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-243,169	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENT INCOME	B	-29,660	CLINIC	90.00	0	33.00
34.00	DR SPACE	B	-2,781	CLINIC	90.00	0	34.00
35.00	IT MISC REVENUE	B	-1,050	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	LOBBYING	A	-5,539	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	36.00
37.00	NEUROLOGY RENT	B	-510	RESPIRATORY THERAPY	65.00	0	37.00
38.00	PHYS RECRUITMENT	A	-58,371	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-55,402	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	39.00
40.00	ADVERTSING- BOWEN	A	-5,207	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING - CLINIC	A	-10,613	CLINIC	90.00	0	41.00
42.00	SUPPLIES SOLD	A	-3,295	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-72,506	CLINIC	90.00	0	43.00
44.00	UNNECESSARY BORROWING	A	-18,773	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-39,549	CLINIC	90.00	0	45.00
45.01			0		0.00	0	45.01
45.02	RENTAL INCOME - MIDWEST	B	-1,793	CLINIC	90.00	0	45.02
45.03			0		0.00	0	45.03
45.04	MISC INCOME	B	-6,740	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.04
45.05	ADVERTISING - WOMENS	A	-12,784	RURAL HEALTH CLINIC	88.00	0	45.05
45.06	OTHER A&G OFFSET	A	-2,939	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.06
45.07	MISC INCOME - PRAIRIE CARDIOVASCULAR	B	-1,525	LABORATORY	60.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-1,799	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.08
45.09	RADIOLOGY	B	-1,893	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	PROVIDER TAX	A	-168,153	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.10
45.11			0		0.00	0	45.11
45.14			0		0.00	0	45.14
45.15	MARKETING SALARIES	A	-56,639	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.15
45.16	MARKETING FRINGES	A	-9,855	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.16
45.17			0		0.00	0	45.17
45.18	CITY OF CARTHAGE INTEREST	A	-18,849	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.18
45.19			0		0.00	0	45.19
45.20			0		0.00	0	45.20
45.21	EXCESS NURSING HOME	B	-31	OTHER LONG TERM CARE	46.00	0	45.21
45.24	NURSING HOME RENTAL INCOME	B	-34,962	OTHER LONG TERM CARE	46.00	0	45.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,355,808				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2013 9:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7.00	OPERATION OF PLANT	RENT	0	80,736	1.00
2.00	88.00	RURAL HEALTH CLINIC	RENT	0	2,331	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	0	83,067	5.00

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

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

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

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

6.00	C	MEMORIAL HOSPIT	100.00	HANCOCK COUNTY NURSING	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-1 Date/Time Prepared: 11/29/2013 9:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-80,736	0		1.00
2.00	-2,331	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-83,067			5.00

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

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

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

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

6.00	SNF-NON-CERTIFIED		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2013 9:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	56.00	RADIOISOTOPE	6,000	0	6,000	0	0	2.00
3.00	60.02	GEO PSYCH	27,082	27,082	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	18,000	0	18,000	0	0	4.00
5.00	90.00	CLINIC	1,018,747	1,018,747	0	0	0	5.00
6.00	91.00	EMERGENCY	1,463,396	261,363	1,202,033	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS	61,106	61,106	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS	915	915	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			2,619,246	1,369,213	1,250,033		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS	0	0	0	0	0	7.00
8.00	4.00	EMPLOYEE BENEFITS	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0		2.00
3.00	60.02	GEO PSYCH	0	0	0	27,082		3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0		4.00
5.00	90.00	CLINIC	0	0	0	1,018,747		5.00
6.00	91.00	EMERGENCY	0	0	0	261,363		6.00
7.00	4.00	EMPLOYEE BENEFITS	0	0	0	61,106		7.00
8.00	4.00	EMPLOYEE BENEFITS	0	0	0	915		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,369,213		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2013 9:56 am

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	342.00	0.00	414.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.39	0.00	37.19	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.19	37.19	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		25,441	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		25,441	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		15,397	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		40,838	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		74.39	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		58,024	22.00
23.00	Total salary equivalency (see instructions)		73,421	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/29/2013 9:56 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.39	0.00	37.19	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	73,421		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	73,421		63.00
64.00	Total cost of outside supplier services (from your records)	46,700		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2013 9:56 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	120.00	0.00	256.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.50	0.00	35.25	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.25	35.25	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		8,460	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		8,460	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		9,024	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		17,484	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		70.50	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		54,990	22.00
23.00	Total salary equivalency (see instructions)		64,014	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.50	0.00	35.25	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		64,014	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		64,014	63.00
64.00	Total cost of outside supplier services (from your records)		17,681	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	120.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.74	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.87	33.87	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	8,129	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	8,129	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	8,129	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	67.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	52,837	22.00
23.00	Total salary equivalency (see instructions)	52,837	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.74	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	52,837		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	52,837		63.00
64.00	Total cost of outside supplier services (from your records)	11,168		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	20,802	20,802				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	86,445	0	86,445			1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	2,296,072	0	0	2,296,072		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	568,056				568,056	2.00
2.01	00201	NEW CAP REL COSTS-NH ME	7,905				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,773,961	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	91,719	0	0	0	0	4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	1,259,972	7,219	6,873	551,497	165,031	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,199,722	0	6,069	0	0	5.02
7.00	00700	OPERATION OF PLANT	554,791	1,100	0	113,797	23,185	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	138,193	0	7,227	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	49,565	0	0	9,853	1,662	8.00
9.00	00900	HOUSEKEEPING	142,282	0	0	24,687	4,164	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	22,386	0	401	0	0	9.01
10.00	01000	DIETARY	128,885	0	0	46,666	7,871	10.00
11.00	01100	CAFETERIA	76,454	0	0	26,581	4,484	11.00
13.00	01300	NURSING ADMINISTRATION	147,917	0	0	14,346	2,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,075	2,258	2,673	42,606	33,202	16.00
17.00	01700	SOCIAL SERVICE	38,204	0	0	9,474	1,598	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	390,865	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,107,261	0	0	529,571	89,333	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	174,956	0	0	12,181	2,055	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	373,417	0	0	216,928	36,590	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	90,118	0	0	47,966	8,090	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,010,024	0	0	239,774	40,443	54.00
56.00	05600	RADIOISOTOPE	77,790	0	0	16,783	2,831	56.00
60.00	06000	LABORATORY	1,117,517	179	0	91,384	16,062	60.00
60.02	06002	GEO PSYCH	221,842	3,011	0	0	10,921	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	45,465	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	204,366	0	0	37,409	6,310	65.00
66.00	06600	PHYSICAL THERAPY	80,314	0	0	14,022	2,365	66.00
69.00	06900	ELECTROCARDIOLOGY	10,867	0	2,035	60,904	23,842	69.00
69.01	06901	PULMONARY REHAB	166,298	2,517	0	0	9,131	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	441,429	0	0	17,649	2,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	91,108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	616,863	91	0	67,726	11,752	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,110,469	0	0	0	0	88.00
90.00	09000	CLINIC	397,812	3,846	0	0	13,953	90.00
91.00	09100	EMERGENCY	1,515,532	0	0	100,262	16,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	59,365	581	0	0	2,109	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,100,084	20,802	25,278	2,292,066	539,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,006	676	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311,613	0	4,213	0	28,088	192.00
194.00	07950	NAUVOO APARTMENTS	21,251	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	56,954	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,432,948	20,802	86,445	2,296,072	568,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	EMPLOYEE BENEFITS DEPARTMENT	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	Subtotal	
			2.01	4.00	4.01	5.01	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME	7,905					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,773,961				4.00
4.01	00401	SHARED HUMAN RESOURCES	0	19,372	111,091			4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	0	119,521	7,512	2,117,625		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	679	222,474	14,315	190,396	1,633,655	5.02
7.00	00700	OPERATION OF PLANT	0	33,236	2,089	96,065	824,263	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	809	0	148	0	146,377	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8,058	69,138	8.00
9.00	00900	HOUSEKEEPING	0	26,394	1,659	26,277	225,463	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	45	0	328	0	23,160	9.01
10.00	01000	DIETARY	0	20,654	1,298	27,093	232,467	10.00
11.00	01100	CAFETERIA	0	16,672	1,048	16,522	141,761	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,238	1,335	24,703	211,959	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,931	2,133	40,879	350,757	16.00
17.00	01700	SOCIAL SERVICE	0	9,590	603	7,845	67,314	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	93,601	5,883	64,687	555,036	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	261,525	16,438	264,387	2,268,515	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	36,417	2,289	30,065	257,963	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	83,010	5,218	94,345	809,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,177	1,205	21,972	188,528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,419	6,626	184,991	1,587,277	54.00
56.00	05600	RADIOISOTOPE	0	0	0	12,850	110,254	56.00
60.00	06000	LABORATORY	0	109,613	6,890	176,991	1,518,636	60.00
60.02	06002	GEO PSYCH	0	18,933	1,190	33,758	289,655	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	5,998	51,463	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,241	2,466	38,230	328,022	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,757	109,458	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,134	134	13,181	113,097	69.00
69.01	06901	PULMONARY REHAB	0	9,083	571	24,748	212,348	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,892	559	62,202	533,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,019	103,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,022	2,138	95,457	828,049	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	187,749	11,801	172,819	1,482,838	88.00
90.00	09000	CLINIC	0	88,948	5,591	67,299	577,449	90.00
91.00	09100	EMERGENCY	0	84,994	5,342	227,305	1,950,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	13,254	833	10,045	86,187	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,533	1,719,094	107,642	2,063,944	17,887,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	618	5,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	54,867	3,449	53,063	455,293	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	21,251	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,372	0	0	0	63,326	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,905	1,773,961	111,091	2,117,625	18,432,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,633,655					5.02
7.00	00700	OPERATION OF PLANT	80,155	904,418				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	14,234	0	160,611			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	6,723	5,464	0	81,325		8.00
9.00	00900	HOUSEKEEPING	21,925	13,691	0	0	261,079	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	2,252	0	972	0	0	9.01
10.00	01000	DIETARY	22,606	25,881	0	0	7,633	10.00
11.00	01100	CAFETERIA	13,786	14,742	0	0	4,348	11.00
13.00	01300	NURSING ADMINISTRATION	20,612	7,956	0	0	2,346	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,109	23,629	6,479	0	6,969	16.00
17.00	01700	SOCIAL SERVICE	6,546	5,254	0	0	1,550	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	53,974	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	220,610	293,698	0	38,109	86,615	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	25,086	6,755	0	0	1,992	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,721	120,307	0	19,109	35,481	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,333	26,601	0	0	7,845	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	154,355	132,977	0	9,783	39,217	54.00
56.00	05600	RADIOISOTOPE	10,722	9,307	0	0	2,745	56.00
60.00	06000	LABORATORY	147,680	50,681	0	474	14,947	60.00
60.02	06002	GEO PSYCH	28,168	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,005	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	31,898	20,747	0	829	6,119	65.00
66.00	06600	PHYSICAL THERAPY	10,644	7,776	0	0	2,293	66.00
69.00	06900	ELECTROCARDIOLOGY	10,998	33,777	4,932	0	9,961	69.00
69.01	06901	PULMONARY REHAB	20,650	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,900	9,788	0	0	2,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,029	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,524	37,560	0	0	11,077	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	144,199	0	0	1,594	0	88.00
90.00	09000	CLINIC	56,154	0	0	1,566	0	90.00
91.00	09100	EMERGENCY	189,661	55,605	0	9,827	16,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	8,381	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,580,640	902,196	12,383	81,291	260,424	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	515	2,222	0	0	655	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,275	0	10,209	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	2,067	0	0	34	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,158	0	138,019	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,633,655	904,418	160,611	81,325	261,079	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.01	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME	26,384					9.01
10.00	01000	DIETARY	0	288,587				10.00
11.00	01100	CAFETERIA	0	0	174,637			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,207	250,080		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	10,080	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,168	3,446	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	288,587	47,541	75,559	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	7,430	11,809	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	12,718	20,212	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,632	4,184	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	16,982	26,990	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	22,887	36,375	0	60.00
60.02	06002	GEO PSYCH	0	0	5,625	8,940	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	8,284	13,166	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	815	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	2,983	4,741	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,976	3,140	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,328	6,878	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	19,319	30,703	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	2,477	3,937	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,886	288,587	174,637	250,080	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	1,687	0	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	22,811	0	0	0	0	194.03
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)	26,384	288,587	174,637	250,080	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
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	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	433,094				16.00
17.00	01700	SOCIAL SERVICE	0	0	80,664			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	614,624		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,482	79,051	0	3,438,767	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,456	0	0	312,491	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,072	0	0	1,121,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,490	0	0	249,613	52.00
53.00	05300	ANESTHESIOLOGY	0	18,492	0	614,624	633,116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,598	0	0	2,065,179	54.00
56.00	05600	RADIOISOTOPE	0	6,148	0	0	139,176	56.00
60.00	06000	LABORATORY	0	102,213	0	0	1,893,893	60.00
60.02	06002	GEO PSYCH	0	6,765	0	0	339,153	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,084	0	0	57,552	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,433	0	0	418,498	65.00
66.00	06600	PHYSICAL THERAPY	0	3,671	0	0	133,842	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,884	0	0	179,464	69.00
69.01	06901	PULMONARY REHAB	0	6,724	0	0	247,446	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,378	0	0	620,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,399	0	0	115,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,603	0	0	989,019	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	29,307	0	0	1,657,938	88.00
90.00	09000	CLINIC	0	6,928	0	0	642,097	90.00
91.00	09100	EMERGENCY	0	26,959	1,613	0	2,300,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	539	0	0	101,521	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	430,625	80,664	614,624	17,656,657	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,692	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,469	0	0	513,933	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	23,352	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	230,314	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	433,094	80,664	614,624	18,432,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part I | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-NH ME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	SHARED HUMAN RESOURCES				4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING NURSING HOME				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,438,767		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	312,491		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,121,128		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	249,613		52.00
53.00	05300	ANESTHESIOLOGY	0	633,116		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,065,179		54.00
56.00	05600	RADIOISOTOPE	0	139,176		56.00
60.00	06000	LABORATORY	0	1,893,893		60.00
60.02	06002	GEO PSYCH	0	339,153		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	57,552		62.00
65.00	06500	RESPIRATORY THERAPY	0	418,498		65.00
66.00	06600	PHYSICAL THERAPY	0	133,842		66.00
69.00	06900	ELECTROCARDIOLOGY	0	179,464		69.00
69.01	06901	PULMONARY REHAB	0	247,446		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	620,777		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	115,555		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	989,019		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,657,938		88.00
90.00	09000	CLINIC	0	642,097		90.00
91.00	09100	EMERGENCY	0	2,300,432		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	101,521		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,656,657		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,692		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	513,933		192.00
194.00	07950	NAUVOO APARTMENTS	0	23,352		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	230,314		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	18,432,948		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	0	7,219	6,873	551,497	165,031	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	6,069	0	0	5.02
7.00	00700	OPERATION OF PLANT	0	1,100	0	113,797	23,185	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	0	7,227	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	9,853	1,662	8.00
9.00	00900	HOUSEKEEPING	0	0	0	24,687	4,164	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	0	401	0	0	9.01
10.00	01000	DIETARY	0	0	0	46,666	7,871	10.00
11.00	01100	CAFETERIA	0	0	0	26,581	4,484	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	14,346	2,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,258	2,673	42,606	33,202	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	9,474	1,598	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	529,571	89,333	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	12,181	2,055	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	216,928	36,590	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	47,966	8,090	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	239,774	40,443	54.00
56.00	05600	RADIOISOTOPE	0	0	0	16,783	2,831	56.00
60.00	06000	LABORATORY	0	179	0	91,384	16,062	60.00
60.02	06002	GEO PSYCH	0	3,011	0	0	10,921	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	37,409	6,310	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,022	2,365	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,035	60,904	23,842	69.00
69.01	06901	PULMONARY REHAB	0	2,517	0	0	9,131	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,649	2,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	91	0	67,726	11,752	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	3,846	0	0	13,953	90.00
91.00	09100	EMERGENCY	0	0	0	100,262	16,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	581	0	0	2,109	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	20,802	25,278	2,292,066	539,292	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,006	676	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,213	0	28,088	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	56,954	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	20,802	86,445	2,296,072	568,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	
			2.01	2A	4.00	4.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0		4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	0	730,620	0	0	730,620	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	679	6,748	0	0	65,690	5.02
7.00	00700	OPERATION OF PLANT	0	138,082	0	0	33,144	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	809	8,036	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,515	0	0	2,780	8.00
9.00	00900	HOUSEKEEPING	0	28,851	0	0	9,066	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	45	446	0	0	0	9.01
10.00	01000	DIETARY	0	54,537	0	0	9,348	10.00
11.00	01100	CAFETERIA	0	31,065	0	0	5,700	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,766	0	0	8,523	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	80,739	0	0	14,104	16.00
17.00	01700	SOCIAL SERVICE	0	11,072	0	0	2,707	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	22,318	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	618,904	0	0	91,221	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	14,236	0	0	10,373	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	253,518	0	0	32,551	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,056	0	0	7,581	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	280,217	0	0	63,825	54.00
56.00	05600	RADIOISOTOPE	0	19,614	0	0	4,433	56.00
60.00	06000	LABORATORY	0	107,625	0	0	61,065	60.00
60.02	06002	GEO PSYCH	0	13,932	0	0	11,647	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	2,069	62.00
65.00	06500	RESPIRATORY THERAPY	0	43,719	0	0	13,190	65.00
66.00	06600	PHYSICAL THERAPY	0	16,387	0	0	4,401	66.00
69.00	06900	ELECTROCARDIOLOGY	0	86,781	0	0	4,548	69.00
69.01	06901	PULMONARY REHAB	0	11,648	0	0	8,539	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,626	0	0	21,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,147	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	79,569	0	0	32,934	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	59,626	88.00
90.00	09000	CLINIC	0	17,799	0	0	23,219	90.00
91.00	09100	EMERGENCY	0	117,173	0	0	78,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	2,690	0	0	3,466	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,533	2,878,971	0	0	712,100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,682	0	0	213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,301	0	0	18,307	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,372	63,326	0	0	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,905	2,979,280	0	0	730,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	72,438					5.02
7.00	00700	OPERATION OF PLANT	3,554	174,780				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	631	0	8,667			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	298	1,056	0	15,649		8.00
9.00	00900	HOUSEKEEPING	972	2,646	0	0	41,535	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	100	0	52	0	0	9.01
10.00	01000	DIETARY	1,002	5,002	0	0	1,214	10.00
11.00	01100	CAFETERIA	611	2,849	0	0	692	11.00
13.00	01300	NURSING ADMINISTRATION	914	1,538	0	0	373	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,512	4,566	350	0	1,109	16.00
17.00	01700	SOCIAL SERVICE	290	1,015	0	0	247	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,393	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,783	56,757	0	7,333	13,779	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,112	1,305	0	0	317	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,491	23,249	0	3,677	5,645	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	813	5,141	0	0	1,248	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,844	25,698	0	1,882	6,239	54.00
56.00	05600	RADIOISOTOPE	475	1,799	0	0	437	56.00
60.00	06000	LABORATORY	6,548	9,794	0	91	2,378	60.00
60.02	06002	GEO PSYCH	1,249	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	222	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,414	4,009	0	160	973	65.00
66.00	06600	PHYSICAL THERAPY	472	1,503	0	0	365	66.00
69.00	06900	ELECTROCARDIOLOGY	488	6,527	266	0	1,585	69.00
69.01	06901	PULMONARY REHAB	916	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,301	1,892	0	0	459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	445	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,571	7,259	0	0	1,762	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,394	0	0	307	0	88.00
90.00	09000	CLINIC	2,490	0	0	301	0	90.00
91.00	09100	EMERGENCY	8,410	10,746	0	1,891	2,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	372	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,087	174,351	668	15,642	41,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23	429	0	0	104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,963	0	551	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	92	0	0	7	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	273	0	7,448	0	0	194.03
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)	72,438	174,780	8,667	15,649	41,535	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.01	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME	598					9.01
10.00	01000	DIETARY	0	71,103				10.00
11.00	01100	CAFETERIA	0	0	40,917			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,689	29,803		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24	0	2,362	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	508	411	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	71,103	11,138	9,005	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,741	1,407	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,980	2,409	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	617	499	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,979	3,216	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	5,362	4,335	0	60.00
60.02	06002	GEO PSYCH	0	0	1,318	1,065	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,941	1,569	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	18	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	699	565	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	463	374	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,014	820	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	4,526	3,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	580	469	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42	71,103	40,917	29,803	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	38	0	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	518	0	0	0	0	194.03
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)	598	71,103	40,917	29,803	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B Part II | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
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	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	104,766				16.00
17.00	01700	SOCIAL SERVICE	0	0	15,331			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	25,630		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,794	15,024		913,841	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	352	0		30,843	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,066	0		333,586	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	360	0		72,315	52.00
53.00	05300	ANESTHESIOLOGY	0	4,474	0		4,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,613	0		415,513	54.00
56.00	05600	RADIOISOTOPE	0	1,487	0		28,245	56.00
60.00	06000	LABORATORY	0	24,714	0		221,912	60.00
60.02	06002	GEO PSYCH	0	1,637	0		30,848	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	262	0		2,553	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,282	0		69,257	65.00
66.00	06600	PHYSICAL THERAPY	0	888	0		24,016	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,424	0		101,637	69.00
69.01	06901	PULMONARY REHAB	0	1,627	0		23,994	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,205	0		51,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	580	0		5,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,985	0		131,914	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,091	0		73,418	88.00
90.00	09000	CLINIC	0	1,676	0		45,485	90.00
91.00	09100	EMERGENCY	0	6,522	307		234,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04042	DIABETIC EDUCATION	0	130	0		7,707	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	104,169	15,331	0	2,822,778	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		5,451	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	597	0		53,757	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		99	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0		71,565	194.03
200.00		Cross Foot Adjustments				25,630	25,630	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	104,766	15,331	25,630	2,979,280	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-NH ME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	SHARED HUMAN RESOURCES				4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING NURSING HOME				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	913,841		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	30,843		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	333,586		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	72,315		52.00
53.00	05300	ANESTHESIOLOGY	0	4,474		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	415,513		54.00
56.00	05600	RADIOISOTOPE	0	28,245		56.00
60.00	06000	LABORATORY	0	221,912		60.00
60.02	06002	GEO PSYCH	0	30,848		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,553		62.00
65.00	06500	RESPIRATORY THERAPY	0	69,257		65.00
66.00	06600	PHYSICAL THERAPY	0	24,016		66.00
69.00	06900	ELECTROCARDIOLOGY	0	101,637		69.00
69.01	06901	PULMONARY REHAB	0	23,994		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	51,781		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	131,914		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	73,418		88.00
90.00	09000	CLINIC	0	45,485		90.00
91.00	09100	EMERGENCY	0	234,267		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	7,707		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,822,778		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,451		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	53,757		192.00
194.00	07950	NAUVOO APARTMENTS	0	99		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	71,565		194.03
200.00		Cross Foot Adjustments	0	25,630		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,979,280		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (OLD HOSP/PBC SQUARE)	NEW NH BLDG (NH/MSS SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	NEW MVBLE EQUIP (HOSP SQUARE FEET)	NEW NH ME (NH SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,264					1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	0	63,117				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	42,412			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				62,209		2.00
2.01	00201	NEW CAP REL COSTS-NH ME				0	51,585	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	2,868	5,018	10,187	18,073	0	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	4,431	0	0	4,431	5.02
7.00	00700	OPERATION OF PLANT	437	0	2,102	2,539	0	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	5,277	0	0	5,277	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	182	182	0	8.00
9.00	00900	HOUSEKEEPING	0	0	456	456	0	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	293	0	0	293	9.01
10.00	01000	DIETARY	0	0	862	862	0	10.00
11.00	01100	CAFETERIA	0	0	491	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	265	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	1,952	787	3,636	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	175	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,782	9,783	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	225	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,007	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	886	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,429	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	310	310	0	56.00
60.00	06000	LABORATORY	71	0	1,688	1,759	0	60.00
60.02	06002	GEO PSYCH	1,196	0	0	1,196	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	691	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	259	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,486	1,125	2,611	0	69.00
69.01	06901	PULMONARY REHAB	1,000	0	0	1,000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	326	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36	0	1,251	1,287	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,528	0	0	1,528	0	90.00
91.00	09100	EMERGENCY	0	0	1,852	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	231	0	0	231	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,264	18,457	42,338	59,059	10,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	74	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	3,076	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	41,584	0	0	41,584	194.03
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)	20,802	86,445	2,296,072	568,056	7,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.517183	1.369599	54.137320	9.131412	0.153242	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (OLD HOSP/PBC SQUARE)	NEW NH BLDG (NH/MSS SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	NEW MVBLE EQUIP (HOSP SQUARE FEET)	NEW NH ME (NH SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (HOSPITAL SALARIES)	SHARED HUMAN RESOURCES (HOSP/NH GROSS SAL)	HOSPITAL ONLY BUS OFF AND A&G (HOSP ONLY ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			4.00	4.01	5.01	5A.02	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,067,299					4.00
4.01	00401	SHARED HUMAN RESOURCES	77,175	7,041,274				4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G	476,162	476,162	16,052,209			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	886,316	907,306	1,443,259	-1,633,655	16,799,293	5.02
7.00	00700	OPERATION OF PLANT	132,411	132,411	728,198	0	824,263	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	9,360	0	0	146,377	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	61,080	0	69,138	8.00
9.00	00900	HOUSEKEEPING	105,151	105,151	199,186	0	225,463	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	20,800	0	0	23,160	9.01
10.00	01000	DIETARY	82,283	82,283	205,374	0	232,467	10.00
11.00	01100	CAFETERIA	66,420	66,420	125,239	0	141,761	11.00
13.00	01300	NURSING ADMINISTRATION	84,609	84,609	187,256	0	211,959	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	135,179	135,179	309,878	0	350,757	16.00
17.00	01700	SOCIAL SERVICE	38,204	38,204	59,469	0	67,314	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	372,896	372,896	490,349	0	555,036	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,041,899	1,041,899	2,004,128	0	2,268,515	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	145,083	145,083	227,898	0	257,963	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	330,703	330,703	715,163	0	809,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,401	76,401	166,556	0	188,528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,980	419,980	1,402,286	0	1,587,277	54.00
56.00	05600	RADIOISOTOPE	0	0	97,404	0	110,254	56.00
60.00	06000	LABORATORY	436,687	436,687	1,341,645	0	1,518,636	60.00
60.02	06002	GEO PSYCH	75,427	75,427	255,897	0	289,655	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	45,465	0	51,463	62.00
65.00	06500	RESPIRATORY THERAPY	156,333	156,333	289,792	0	328,022	65.00
66.00	06600	PHYSICAL THERAPY	0	0	96,701	0	109,458	66.00
69.00	06900	ELECTROCARDIOLOGY	8,501	8,501	99,916	0	113,097	69.00
69.01	06901	PULMONARY REHAB	36,185	36,185	187,600	0	212,348	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,423	35,423	471,506	0	533,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	91,108	0	103,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,540	135,540	723,592	0	828,049	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	747,973	747,973	1,310,019	0	1,482,838	88.00
90.00	09000	CLINIC	354,360	354,360	510,150	0	577,449	90.00
91.00	09100	EMERGENCY	338,610	338,610	1,723,041	0	1,950,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	52,802	52,802	76,142	0	86,187	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,848,713	6,822,688	15,645,297	-1,633,655	16,254,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,682	0	5,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,586	218,586	402,230	0	455,293	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	21,251	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	63,326	194.03
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)	1,773,961	111,091	2,117,625		1,633,655	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.251010	0.015777	0.131921		0.097245	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	730,620		72,438	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.045515		0.004312	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT NURSING HOME (NH/MSS SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOSP ONLY SQUARE FT)	HOUSEKEEPING NURSING HOME (NH/MSS SQUARE FEET)	
			7.00	7.01	8.00	9.00	9.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT	30,123					7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	48,391				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	182	0	80,256			8.00
9.00	00900	HOUSEKEEPING	456	0	0	29,485		9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	293	0	0	48,098	9.01
10.00	01000	DIETARY	862	0	0	862	0	10.00
11.00	01100	CAFETERIA	491	0	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	265	0	0	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	787	1,952	0	787	1,952	16.00
17.00	01700	SOCIAL SERVICE	175	0	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,782	0	37,608	9,782	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	225	0	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,007	0	18,858	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	886	0	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,429	0	9,654	4,429	0	54.00
56.00	05600	RADIOISOTOPE	310	0	0	310	0	56.00
60.00	06000	LABORATORY	1,688	0	468	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	691	0	818	691	0	65.00
66.00	06600	PHYSICAL THERAPY	259	0	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,125	1,486	0	1,125	1,486	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	326	0	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,251	0	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,573	0	0	88.00
90.00	09000	CLINIC	0	0	1,545	0	0	90.00
91.00	09100	EMERGENCY	1,852	0	9,698	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,049	3,731	80,222	29,411	3,438	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74	0	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	0	3,076	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	34	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	41,584	0	0	41,584	194.03
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)	904,418	160,611	81,325	261,079	26,384	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.024168	3.319026	1.013320	8.854638	0.548547	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	174,780	8,667	15,649	41,535	598	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.802211	0.179104	0.194989	1.408682	0.012433	205.00

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		Cost Center Description	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
10.00	01000	DIETARY	2,773					10.00
11.00	01100	CAFETERIA	0	171,224				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,066	154,275			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,883	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,126	2,126	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,773	46,612	46,612	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	7,285	7,285	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,469	12,469	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,581	2,581	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,650	16,650	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	22,440	22,440	0	0	60.00
60.02	06002	GEO PSYCH	0	5,515	5,515	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,122	8,122	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	2,925	2,925	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,937	1,937	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,243	4,243	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	18,941	18,941	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	2,429	2,429	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,773	171,224	154,275	0	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
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	0	194.03
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)	288,587	174,637	250,080	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	104.070321	1.019933	1.621001	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	71,103	40,917	29,803	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.641183	0.238968	0.193181	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet B-1 | Date/Time Prepared: 11/29/2013 9:56 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG					1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-NH ME					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	SHARED HUMAN RESOURCES					4.01
5.01	00510	HOSPITAL ONLY BUS OFF AND A&G					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT NURSING HOME					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING NURSING HOME					9.01
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	30,486,044				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,849,672	98			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
43.00	04300	NURSERY	102,492	0			43.00
46.00	04600	OTHER LONG TERM CARE	0	0			46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,764,883	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,859	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,301,691	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,870,227	0	0		54.00
56.00	05600	RADIOISOTOPE	432,759	0	0		56.00
60.00	06000	LABORATORY	7,194,382	0	0		60.00
60.02	06002	GEO PSYCH	476,223	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,276	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	664,031	0	0		65.00
66.00	06600	PHYSICAL THERAPY	258,430	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	414,194	0	0		69.00
69.01	06901	PULMONARY REHAB	473,292	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,223,318	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	168,858	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,450,336	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,063,005	0	0		88.00
90.00	09000	CLINIC	487,658	0	0		90.00
91.00	09100	EMERGENCY	1,897,690	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	37,947	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,312,223	100	2,080		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	173,821	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0		194.03
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)	433,094	80,664	614,624		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014206	806.640000	295.492308		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	104,766	15,331	25,630		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003437	153.310000	12.322115		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		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	3,438,767		3,438,767	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	312,491		312,491	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,121,128		1,121,128	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,613		249,613	0	0	52.00
53.00	05300	ANESTHESIOLOGY	633,116		633,116	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,179		2,065,179	0	0	54.00
56.00	05600	RADIOISOTOPE	139,176		139,176	0	0	56.00
60.00	06000	LABORATORY	1,893,893		1,893,893	0	0	60.00
60.02	06002	GEO PSYCH	339,153		339,153	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,552		57,552	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	418,498	0	418,498	0	0	65.00
66.00	06600	PHYSICAL THERAPY	133,842	0	133,842	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	179,464		179,464	0	0	69.00
69.01	06901	PULMONARY REHAB	247,446		247,446	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,777		620,777	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,555		115,555	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,019		989,019	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,657,938		1,657,938	0	0	88.00
90.00	09000	CLINIC	642,097		642,097	0	0	90.00
91.00	09100	EMERGENCY	2,300,432		2,300,432	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,170		438,170		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,521		101,521	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,094,827	0	18,094,827	0	0	200.00
201.00		Less Observation Beds	438,170		438,170		0	201.00
202.00		Total (see instructions)	17,656,657	0	17,656,657	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,205,836		2,205,836			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	102,492		102,492			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,877	1,286,006	1,764,883	0.635242	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,314	545	104,859	2.380463	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	300,959	1,000,732	1,301,691	0.486380	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	595,102	6,275,125	6,870,227	0.300598	0.000000	54.00
56.00	05600	RADIOISOTOPE	18,005	414,754	432,759	0.321602	0.000000	56.00
60.00	06000	LABORATORY	890,856	6,303,526	7,194,382	0.263246	0.000000	60.00
60.02	06002	GEO PSYCH	0	476,223	476,223	0.712173	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,675	42,601	76,276	0.754523	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	256,182	407,849	664,031	0.630239	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	256,050	2,380	258,430	0.517904	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	32,322	381,872	414,194	0.433285	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	473,292	473,292	0.522819	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	646,236	577,082	1,223,318	0.507453	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,197	52,661	168,858	0.684332	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,629	846,707	1,450,336	0.681924	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,063,005	2,063,005			88.00
90.00	09000	CLINIC	0	487,658	487,658	1.316695	0.000000	90.00
91.00	09100	EMERGENCY	13,674	1,884,016	1,897,690	1.212227	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,793	634,043	643,836	0.680562	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04042	DIABETIC EDUCATION	0	37,947	37,947	2.675337	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,664,199	23,648,024	30,312,223			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,664,199	23,648,024	30,312,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
60.02	06002	GEO PSYCH	0.000000		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04042	DIABETIC EDUCATION	0.000000		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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	3,438,767		3,438,767	0	3,438,767	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	312,491		312,491	0	312,491	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,121,128		1,121,128	0	1,121,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,613		249,613	0	249,613	52.00
53.00	05300	ANESTHESIOLOGY	633,116		633,116	0	633,116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,179		2,065,179	0	2,065,179	54.00
56.00	05600	RADIOISOTOPE	139,176		139,176	0	139,176	56.00
60.00	06000	LABORATORY	1,893,893		1,893,893	0	1,893,893	60.00
60.02	06002	GEO PSYCH	339,153		339,153	0	339,153	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,552		57,552	0	57,552	62.00
65.00	06500	RESPIRATORY THERAPY	418,498	0	418,498	0	418,498	65.00
66.00	06600	PHYSICAL THERAPY	133,842	0	133,842	0	133,842	66.00
69.00	06900	ELECTROCARDIOLOGY	179,464		179,464	0	179,464	69.00
69.01	06901	PULMONARY REHAB	247,446		247,446	0	247,446	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,777		620,777	0	620,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,555		115,555	0	115,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,019		989,019	0	989,019	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,657,938		1,657,938	0	1,657,938	88.00
90.00	09000	CLINIC	642,097		642,097	0	642,097	90.00
91.00	09100	EMERGENCY	2,300,432		2,300,432	0	2,300,432	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,170		438,170		438,170	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,521		101,521	0	101,521	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,094,827	0	18,094,827	0	18,094,827	200.00
201.00		Less Observation Beds	438,170		438,170		438,170	201.00
202.00		Total (see instructions)	17,656,657	0	17,656,657	0	17,656,657	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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	2,205,836		2,205,836			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	102,492		102,492			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,877	1,286,006	1,764,883	0.635242	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	104,314	545	104,859	2.380463	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	300,959	1,000,732	1,301,691	0.486380	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	595,102	6,275,125	6,870,227	0.300598	0.000000	54.00
56.00	05600	RADIOISOTOPE	18,005	414,754	432,759	0.321602	0.000000	56.00
60.00	06000	LABORATORY	890,856	6,303,526	7,194,382	0.263246	0.000000	60.00
60.02	06002	GEO PSYCH	0	476,223	476,223	0.712173	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,675	42,601	76,276	0.754523	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	256,182	407,849	664,031	0.630239	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	256,050	2,380	258,430	0.517904	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	32,322	381,872	414,194	0.433285	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	473,292	473,292	0.522819	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	646,236	577,082	1,223,318	0.507453	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,197	52,661	168,858	0.684332	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	603,629	846,707	1,450,336	0.681924	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,063,005	2,063,005	0.803652	0.000000	88.00
90.00	09000	CLINIC	0	487,658	487,658	1.316695	0.000000	90.00
91.00	09100	EMERGENCY	13,674	1,884,016	1,897,690	1.212227	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,793	634,043	643,836	0.680562	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04042	DIABETIC EDUCATION	0	37,947	37,947	2.675337	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,664,199	23,648,024	30,312,223			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,664,199	23,648,024	30,312,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.635242		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.380463		52.00
53.00	05300	ANESTHESIOLOGY	0.486380		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300598		54.00
56.00	05600	RADIOISOTOPE	0.321602		56.00
60.00	06000	LABORATORY	0.263246		60.00
60.02	06002	GEO PSYCH	0.712173		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.754523		62.00
65.00	06500	RESPIRATORY THERAPY	0.630239		65.00
66.00	06600	PHYSICAL THERAPY	0.517904		66.00
69.00	06900	ELECTROCARDIOLOGY	0.433285		69.00
69.01	06901	PULMONARY REHAB	0.522819		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.681924		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.803652		88.00
90.00	09000	CLINIC	1.316695		90.00
91.00	09100	EMERGENCY	1.212227		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680562		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04042	DIABETIC EDUCATION	2.675337		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part II Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | Hospital | PPS

		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	1,121,128	333,586	787,542	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,613	72,315	177,298	0	0	52.00
53.00	05300	ANESTHESIOLOGY	633,116	4,474	628,642	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,179	415,513	1,649,666	0	0	54.00
56.00	05600	RADIOISOTOPE	139,176	28,245	110,931	0	0	56.00
60.00	06000	LABORATORY	1,893,893	221,912	1,671,981	0	0	60.00
60.02	06002	GEO PSYCH	339,153	30,848	308,305	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,552	2,553	54,999	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	418,498	69,257	349,241	0	0	65.00
66.00	06600	PHYSICAL THERAPY	133,842	24,016	109,826	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	179,464	101,637	77,827	0	0	69.00
69.01	06901	PULMONARY REHAB	247,446	23,994	223,452	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,777	51,781	568,996	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,555	5,172	110,383	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,019	131,914	857,105	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,657,938	73,418	1,584,520	0	0	88.00
90.00	09000	CLINIC	642,097	45,485	596,612	0	0	90.00
91.00	09100	EMERGENCY	2,300,432	234,267	2,066,165	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,170	0	438,170	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,521	7,707	93,814	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,343,569	1,878,094	12,465,475	0	0	200.00
201.00		Less Observation Beds	438,170	0	438,170	0	0	201.00
202.00		Total (line 200 minus line 201)	13,905,399	1,878,094	12,027,305	0	0	202.00

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

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet C Part II Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | Hospital | PPS

		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	1,121,128	1,764,883	0.635242		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	249,613	104,859	2.380463		52.00
53.00	05300	ANESTHESIOLOGY	633,116	1,301,691	0.486380		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,065,179	6,870,227	0.300598		54.00
56.00	05600	RADIOISOTOPE	139,176	432,759	0.321602		56.00
60.00	06000	LABORATORY	1,893,893	7,194,382	0.263246		60.00
60.02	06002	GEO PSYCH	339,153	476,223	0.712173		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,552	76,276	0.754523		62.00
65.00	06500	RESPIRATORY THERAPY	418,498	664,031	0.630239		65.00
66.00	06600	PHYSICAL THERAPY	133,842	258,430	0.517904		66.00
69.00	06900	ELECTROCARDIOLOGY	179,464	414,194	0.433285		69.00
69.01	06901	PULMONARY REHAB	247,446	473,292	0.522819		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	620,777	1,223,318	0.507453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	115,555	168,858	0.684332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,019	1,450,336	0.681924		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,657,938	2,063,005	0.803652		88.00
90.00	09000	CLINIC	642,097	487,658	1.316695		90.00
91.00	09100	EMERGENCY	2,300,432	1,897,690	1.212227		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	438,170	643,836	0.680562		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04042	DIABETIC EDUCATION	101,521	37,947	2.675337		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,343,569	28,003,895			200.00
201.00		Less Observation Beds	438,170	0			201.00
202.00		Total (line 200 minus line 201)	13,905,399	28,003,895			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	333,586	1,764,883	0.189013	113,277	21,411	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	72,315	104,859	0.689640	1,444	996	52.00
53.00	05300	ANESTHESIOLOGY	4,474	1,301,691	0.003437	60,293	207	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,513	6,870,227	0.060480	365,863	22,127	54.00
56.00	05600	RADIOISOTOPE	28,245	432,759	0.065267	10,397	679	56.00
60.00	06000	LABORATORY	221,912	7,194,382	0.030845	376,939	11,627	60.00
60.02	06002	GEO PSYCH	30,848	476,223	0.064776	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,553	76,276	0.033471	21,698	726	62.00
65.00	06500	RESPIRATORY THERAPY	69,257	664,031	0.104298	152,742	15,931	65.00
66.00	06600	PHYSICAL THERAPY	24,016	258,430	0.092930	53,957	5,014	66.00
69.00	06900	ELECTROCARDIOLOGY	101,637	414,194	0.245385	14,178	3,479	69.00
69.01	06901	PULMONARY REHAB	23,994	473,292	0.050696	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,781	1,223,318	0.042328	297,095	12,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,172	168,858	0.030629	86,116	2,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,914	1,450,336	0.090954	292,538	26,608	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	73,418	2,063,005	0.035588	0	0	88.00
90.00	09000	CLINIC	45,485	487,658	0.093272	0	0	90.00
91.00	09100	EMERGENCY	234,267	1,897,690	0.123449	1,132	140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	643,836	0.000000	728	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	7,707	37,947	0.203099	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,878,094	28,003,895		1,848,397	124,158	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	614,624	0	0	0	614,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	614,624	0	0	0	614,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,764,883	0.000000	0.000000	113,277	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	104,859	0.000000	0.000000	1,444	52.00
53.00	05300	ANESTHESIOLOGY	0	1,301,691	0.472174	0.000000	60,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,870,227	0.000000	0.000000	365,863	54.00
56.00	05600	RADIOISOTOPE	0	432,759	0.000000	0.000000	10,397	56.00
60.00	06000	LABORATORY	0	7,194,382	0.000000	0.000000	376,939	60.00
60.02	06002	GEO PSYCH	0	476,223	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	76,276	0.000000	0.000000	21,698	62.00
65.00	06500	RESPIRATORY THERAPY	0	664,031	0.000000	0.000000	152,742	65.00
66.00	06600	PHYSICAL THERAPY	0	258,430	0.000000	0.000000	53,957	66.00
69.00	06900	ELECTROCARDIOLOGY	0	414,194	0.000000	0.000000	14,178	69.00
69.01	06901	PULMONARY REHAB	0	473,292	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,223,318	0.000000	0.000000	297,095	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,858	0.000000	0.000000	86,116	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,450,336	0.000000	0.000000	292,538	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,063,005	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	487,658	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,897,690	0.000000	0.000000	1,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	643,836	0.000000	0.000000	728	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04042	DIABETIC EDUCATION	0	37,947	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	28,003,895			1,848,397	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	28,469	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	28,469	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.635242	0	443,203	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.380463	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.486380	0	326,628	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300598	0	2,399,712	0	0	54.00
56.00	05600	RADIOISOTOPE	0.321602	0	178,379	0	0	56.00
60.00	06000	LABORATORY	0.263246	0	2,546,647	0	0	60.00
60.02	06002	GEO PSYCH	0.712173	0	445,630	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.754523	0	29,772	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.630239	0	358,405	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.517904	0	1,710	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.433285	0	174,619	0	0	69.00
69.01	06901	PULMONARY REHAB	0.522819	0	253,176	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507453	0	214,819	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684332	0	26,357	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.681924	0	531,643	14,441	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.316695	0	194,195	0	0	90.00
91.00	09100	EMERGENCY	1.212227	0	695,065	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680562	0	308,037	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.675337	0	13,148	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	9,141,145	14,441	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,141,145	14,441	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	281,541	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	158,865	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	721,349	0		54.00
56.00	05600	RADIOISOTOPE	57,367	0		56.00
60.00	06000	LABORATORY	670,395	0		60.00
60.02	06002	GEO PSYCH	317,366	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,464	0		62.00
65.00	06500	RESPIRATORY THERAPY	225,881	0		65.00
66.00	06600	PHYSICAL THERAPY	886	0		66.00
69.00	06900	ELECTROCARDIOLOGY	75,660	0		69.00
69.01	06901	PULMONARY REHAB	132,365	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,011	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,037	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	362,540	9,848		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	255,696	0		90.00
91.00	09100	EMERGENCY	842,577	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,638	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	35,175	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,496,813	9,848		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,496,813	9,848		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/29/2013 9:56 am

Component CCN: 14Z305 | Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.635242	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.380463	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.486380	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300598	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.321602	0	0	0	0	56.00
60.00	06000	LABORATORY	0.263246	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.712173	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.754523	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.630239	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.517904	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.433285	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.522819	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507453	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684332	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.681924	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.316695	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.212227	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680562	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.675337	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part V | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GEO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part I Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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	913,841	262,291	651,550	1,950	334.13	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	30,843		30,843	250	123.37	43.00
200.00	Total (lines 30-199)	944,684		682,393	2,200		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	240	80,191				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	96	11,844				43.00
200.00	Total (lines 30-199)	336	92,035				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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	333,586	1,764,883	0.189013	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	72,315	104,859	0.689640	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,474	1,301,691	0.003437	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,513	6,870,227	0.060480	0	0	54.00
56.00	05600	RADIOISOTOPE	28,245	432,759	0.065267	0	0	56.00
60.00	06000	LABORATORY	221,912	7,194,382	0.030845	0	0	60.00
60.02	06002	GEO PSYCH	30,848	476,223	0.064776	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,553	76,276	0.033471	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	69,257	664,031	0.104298	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,016	258,430	0.092930	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101,637	414,194	0.245385	0	0	69.00
69.01	06901	PULMONARY REHAB	23,994	473,292	0.050696	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,781	1,223,318	0.042328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,172	168,858	0.030629	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,914	1,450,336	0.090954	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	73,418	2,063,005	0.035588	0	0	88.00
90.00	09000	CLINIC	45,485	487,658	0.093272	0	0	90.00
91.00	09100	EMERGENCY	234,267	1,897,690	0.123449	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	163,554	643,836	0.254031	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	7,707	37,947	0.203099	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,041,648	28,003,895		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part III Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,950	0.00	240	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
43.00	04300	NURSERY	250	0.00	96	0		43.00
200.00		Total (lines 30-199)	2,200		336	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	614,624	0	0	0	614,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	614,624	0	0	0	614,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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	1,764,883	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	104,859	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,301,691	0.472174	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,870,227	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	432,759	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	7,194,382	0.000000	0.000000	0	60.00
60.02	06002	GEO PSYCH	0	476,223	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	76,276	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	664,031	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	258,430	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	414,194	0.000000	0.000000	0	69.00
69.01	06901	PULMONARY REHAB	0	473,292	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,223,318	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,858	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,450,336	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,063,005	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	487,658	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,897,690	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	643,836	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04042	DIABETIC EDUCATION	0	37,947	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	28,003,895			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part I Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

	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	913,841	0	913,841	1,950	468.64	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	30,843		30,843	250	123.37	43.00
200.00	Total (lines 30-199)	944,684		944,684	2,200		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	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part II Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

		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	333,586	0	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	72,315	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,474	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	415,513	0	0.000000	0	0	54.00
56.00	05600	RADIOISOTOPE	28,245	0	0.000000	0	0	56.00
60.00	06000	LABORATORY	221,912	0	0.000000	0	0	60.00
60.02	06002	GEO PSYCH	30,848	0	0.000000	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,553	0	0.000000	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	69,257	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,016	0	0.000000	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	101,637	0	0.000000	0	0	69.00
69.01	06901	PULMONARY REHAB	23,994	0	0.000000	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,781	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,172	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,914	0	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	73,418	0	0.000000	0	0	88.00
90.00	09000	CLINIC	45,485	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	234,267	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	7,707	0	0.000000	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,878,094	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part III Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

		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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,950	0.00	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
43.00	04300	NURSERY	250	0.00	0	0		43.00
200.00		Total (lines 30-199)	2,200		0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	614,624	0	0	0	614,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	614,624	0	0	0	614,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

		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	0	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	0	0.000000	0.000000	0	60.00
60.02	06002	GEO PSYCH	0	0	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D Part IV | Date/Time Prepared: 11/29/2013 9:56 am

Title V | Hospital

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,950	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,601	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	392	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)	393	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,025	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)	388	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)	387	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	128.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,438,767	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,446	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)	2,520	25.00
26.00	Total swing-bed cost (see instructions)	990,533	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,448,234	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,448,234	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,255.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,286,888	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,286,888	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	875,044	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,161,932	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	487,134	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	485,879	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	973,013	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)	349	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,255.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	438,170	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | 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)	2,773	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,950	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,601	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	785	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	240	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	250	15.00
16.00	Nursery days (title V or XIX only)	96	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,438,767	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	986,996	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,451,771	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,451,771	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,257.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	301,757	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)	301,757	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	312,491	250	1,249.96	96	119,996	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	421,753	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)	92,035	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	92,035	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	329,718	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	349	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,257.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	438,805	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-1 | Date/Time Prepared: 11/29/2013 9:56 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	913,841	2,451,771	0.372727	438,805	163,554	90.00
91.00	Nursing School cost	0	2,451,771	0.000000	438,805	0	91.00
92.00	Allied health cost	0	2,451,771	0.000000	438,805	0	92.00
93.00	All other Medical Education	0	2,451,771	0.000000	438,805	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,017,073		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	0.635242	113,277	71,958	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.380463	1,444	3,437	52.00
53.00	05300	ANESTHESIOLOGY	0.486380	60,293	29,325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300598	365,863	109,978	54.00
56.00	05600	RADIOISOTOPE	0.321602	10,397	3,344	56.00
60.00	06000	LABORATORY	0.263246	376,939	99,228	60.00
60.02	06002	GEO PSYCH	0.712173	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.754523	21,698	16,372	62.00
65.00	06500	RESPIRATORY THERAPY	0.630239	152,742	96,264	65.00
66.00	06600	PHYSICAL THERAPY	0.517904	53,957	27,945	66.00
69.00	06900	ELECTROCARDIOLOGY	0.433285	14,178	6,143	69.00
69.01	06901	PULMONARY REHAB	0.522819	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507453	297,095	150,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684332	86,116	58,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.681924	292,538	199,489	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.316695	0	0	90.00
91.00	09100	EMERGENCY	1.212227	1,132	1,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680562	728	495	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.675337	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,848,397	875,044	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,848,397		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet D-3 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.635242	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.380463	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.486380	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.300598	53,172	15,983	54.00
56.00	05600	RADIOISOTOPE	0.321602	0	0	56.00
60.00	06000	LABORATORY	0.263246	98,695	25,981	60.00
60.02	06002	GEO PSYCH	0.712173	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.754523	2,364	1,784	62.00
65.00	06500	RESPIRATORY THERAPY	0.630239	70,901	44,685	65.00
66.00	06600	PHYSICAL THERAPY	0.517904	182,098	94,309	66.00
69.00	06900	ELECTROCARDIOLOGY	0.433285	2,041	884	69.00
69.01	06901	PULMONARY REHAB	0.522819	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.507453	92,231	46,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.684332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.681924	106,573	72,675	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.316695	0	0	90.00
91.00	09100	EMERGENCY	1.212227	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680562	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.675337	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		608,075	303,104	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)		608,075		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/29/2013 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,506,661	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,506,661	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,551,728	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	55,814	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,340,328	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,155,586	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,155,586	30.00
31.00	Primary payer payments	656	31.00
32.00	Subtotal (line 30 minus line 31)	3,154,930	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)	255,803	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	255,803	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	225,263	36.00
37.00	Subtotal (see instructions)	3,410,733	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)	3,410,733	40.00
40.01	Sequestration adjustment (see instructions)	17,054	40.01
41.00	Interim payments	3,282,439	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	111,240	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,755,577		3,282,439	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/31/2013	102,158		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)		102,158		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)		1,857,735		3,282,439	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		118,656		128,294	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,976,391		3,410,733	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: 141305 | Component CCN: 14Z305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,141,987		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	01/31/2013	42,105		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)		42,105		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)		1,184,092		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		80,217		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,264,309		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: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/29/2013 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	527	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,025	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	9	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,601	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	30,312,223	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	423,901	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	505,585	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	432,174	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	432,174	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	432,174	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet E-2 | Date/Time Prepared: 11/29/2013 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	982,743	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)	306,135	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	775	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)	1,288,878	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,288,878	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)	1,288,878	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	24,569	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)	1,264,309	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)	1,264,309	0	19.00
19.01	Sequestration adjustment (see instructions)	6,322	0	19.01
20.00	Interim payments	1,184,092	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	73,895	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/29/2013 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,161,932	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,161,932	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,183,551	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,183,551	19.00
20.00	Deductibles (exclude professional component)	245,505	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,938,046	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,938,046	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	38,345	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	38,345	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,174	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,976,391	28.00
29.00		0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,976,391	30.00
30.01	Sequestration adjustment (see instructions)	9,882	30.01
31.00	Interim payments	1,857,735	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	108,774	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G | Date/Time Prepared: 11/29/2013 9:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,248,639	0	0	0	1.00
2.00	Temporary investments	84,039	0	0	0	2.00
3.00	Notes receivable	1,936	0	0	0	3.00
4.00	Accounts receivable	3,626,743	0	0	0	4.00
5.00	Other receivable	928,293	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-577,000	0	0	0	6.00
7.00	Inventory	271,325	0	0	0	7.00
8.00	Prepaid expenses	114,791	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,698,766	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	521,757	0	0	0	12.00
13.00	Land improvements	346,855	0	0	0	13.00
14.00	Accumulated depreciation	-172,727	0	0	0	14.00
15.00	Buildings	26,146,612	0	0	0	15.00
16.00	Accumulated depreciation	-6,952,295	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	2,794,603	0	0	0	23.00
24.00	Accumulated depreciation	-3,787,824	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	1,331,937	0	0	0	27.00
28.00	Accumulated depreciation	-1,069,521	0	0	0	28.00
29.00	Minor equipment-nondepreciable	426,710	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,586,107	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,620,680	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	2,118,219	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,738,899	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,023,772	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	737,773	0	0	0	37.00
38.00	Salaries, wages, and fees payable	492,863	0	0	0	38.00
39.00	Payroll taxes payable	172,471	0	0	0	39.00
40.00	Notes and loans payable (short term)	546,002	0	0	0	40.00
41.00	Deferred income	12,221	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	83,462	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,044,792	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	19,391,077	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	19,391,077	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	21,435,869	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16,587,903				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)	16,587,903	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,023,772	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-1 | Date/Time Prepared: 11/29/2013 9:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,964,778		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,190,145				2.00
3.00	Total (sum of line 1 and line 2)		16,154,923		0		3.00
4.00	CONTRIBUTIONS	432,980		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)		432,980		0		10.00
11.00	Subtotal (line 3 plus line 10)		16,587,903		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,587,903		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	CONTRIBUTIONS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/29/2013 9:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,462,566		2,462,566	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	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,462,566		2,462,566	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,462,566		2,462,566	17.00
18.00	Ancillary services	4,390,926	0	4,390,926	18.00
19.00	Outpatient services	0	26,522,422	26,522,422	19.00
20.00	RURAL HEALTH CLINIC	0	2,063,005	2,063,005	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	173,821	173,821	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,853,492	28,759,248	35,612,740	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,788,756		29.00
30.00		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		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)		20,788,756		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141305 | Period: From 07/01/2012 To 06/30/2013 | Worksheet G-3 | Date/Time Prepared: 11/29/2013 9:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,612,740	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,446,714	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,166,026	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,788,756	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-622,730	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	8,992	6.00
7.00	Income from investments	506,614	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	1,799	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	31,076	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	3,632	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	49,693	22.00
23.00	Governmental appropriations	50,424	23.00
24.00	HOSPITAL OTHER INCOME	34,750	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	30,002	24.01
24.02	NURSING HOME OTHER INCOME	164,019	24.02
24.03		0	24.03
24.04	GAIN ON DISPOSAL	12,096	24.04
24.05	SALARY REIMBURSEMENTS	172,728	24.05
24.06	EHR INCENTIVE	747,050	24.06
25.00	Total other income (sum of lines 6-24)	1,812,875	25.00
26.00	Total (line 5 plus line 25)	1,190,145	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,190,145	29.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/29/2013 9:56 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	319,204	0	319,204	-33,558	285,646	1.00
2.00	Physician Assistant	295,693	0	295,693	-19,805	275,888	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	228,041	0	228,041	-41,602	186,439	9.00
10.00	Subtotal (sum of lines 1-9)	842,938	0	842,938	-94,965	747,973	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	101,041	101,041	0	101,041	12.00
13.00	Other Costs Under Agreement	0	4,302	4,302	0	4,302	13.00
14.00	Subtotal (sum of lines 11-13)	0	105,343	105,343	0	105,343	14.00
15.00	Medical Supplies	0	89,733	89,733	0	89,733	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	2,560	2,560	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	46,067	46,067	0	46,067	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	135,800	135,800	2,560	138,360	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	842,938	241,143	1,084,081	-92,405	991,676	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	139,115	139,115	0	139,115	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	139,115	139,115	0	139,115	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	842,938	380,258	1,223,196	-92,405	1,130,791	32.00

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-1 | Date/Time Prepared: 11/29/2013 9:56 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	285,646		1.00
2.00	Physician Assistant	0	275,888		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	186,439		9.00
10.00	Subtotal (sum of lines 1-9)	0	747,973		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	101,041		12.00
13.00	Other Costs Under Agreement	0	4,302		13.00
14.00	Subtotal (sum of lines 11-13)	0	105,343		14.00
15.00	Medical Supplies	0	89,733		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	2,560		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	46,067		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	138,360		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	991,676		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	-20,322	118,793		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-20,322	118,793		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,322	1,110,469		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141305 Component CCN: 143456

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

Worksheet M-2

Date/Time Prepared: 11/29/2013 9:56 am

Rural Health Clinic (RHC) I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.95	2,237	4,200	3,990		1.00
2.00	Physician Assistant	1.90	4,822	2,100	3,990		2.00
3.00	Nurse Practitioner	0.90	2,500	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1-3)	3.75	9,559		9,870	9,870	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)	3.75	9,559			9,870	8.00
9.00	Physician Services Under Agreements		173			173	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)					991,676	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)					991,676	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)					118,793	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					547,469	15.00
16.00	Total overhead (sum of lines 14 and 15)					666,262	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					666,262	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					666,262	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,657,938	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3 Date/Time Prepared: 11/29/2013 9:56 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,657,938	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		3,337	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,654,601	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,870	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		173	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,043	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.75	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)	164.75	164.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,336	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	220,106	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) *		220,106	16.00
16.01	Total program charges (see instructions)(from contractor's records)		225,274	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		39,174	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		38,275	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.)		131,094	16.04
16.05	Total program cost (see instructions)		169,369	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,964	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,627	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		169,369	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,449	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		170,818	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)		170,818	26.00
26.01	Sequestration adjustment (see instructions)		854	26.01
27.00	Interim payments		135,888	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		34,076	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2012 To 06/30/2013 | Worksheet M-4 | Date/Time Prepared: 11/29/2013 9:56 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	747,973	747,973	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000912	0.000052	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	682	39	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	303	972	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	985	1,011	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	991,676	991,676	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	666,262	666,262	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000993	0.001019	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	662	679	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,647	1,690	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	88	181	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	18.72	9.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	38	79	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	711	738	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,337	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,449	16.00

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

Provider CCN: 141305 Component CCN: 143456

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

Worksheet M-5

Date/Time Prepared: 11/29/2013 9:56 am

Rural Health Clinic (RHC) I

Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		122,091	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		01/31/2013	13,797	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)		13,797	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		135,888	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		34,930	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		170,818	7.00

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