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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet S Parts I-III Date/Time Prepared: 1/26/2015 1:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/26/2015 Time: 1:13 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SHELBY MEMORIAL HOSPITAL (140019) for the cost reporting period beginning 09/01/2013 and ending 08/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-100,763	-17,158	283,563	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-19,205		0	10.00
200.00	Total	0	-100,763	-36,363	283,563	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 SOUTH CEDAR	PO Box:			1.00
2.00	City: SHELBYBILLE	State: IL	Zip Code: 62565-1899	County: SHELBY	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	SHELBY MEMORIAL HOSPITAL	140019	99914	1	07/01/1966	N	P	N	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	SHELBY MEMORIAL HOSPITAL SWING BED	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SHELBY MEMORIAL HOSPITAL HHA	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHELBY MEMORIAL HOSPITAL RHC	143446	99914		06/05/1998	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)	09/01/2013	08/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	360	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	09/01/2013	08/31/2014	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)	Y	Y	39.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 1:09 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 1:09 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 1:09 pm

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	155,913	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 1/26/2015 1:09 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	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)	09/01/2013	08/31/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 1/26/2015 1:09 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/30/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 1/26/2015 1:09 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	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.	KEVIN	WELLEN, CPA	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	STLHEATHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 1/26/2015 1:09 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	09/30/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		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: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,950	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,950	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		30	10,950	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		30				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	850	360	1,499			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	341	0	341			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	57			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,191	360	1,897			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)	1,191	360	1,897	0.00	128.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,533	0	4,232	0.00	7.36	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,361	0	6,620	0.00	9.95	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	145.51	27.00
28.00	Observation Bed Days		50	428			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			18			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	265	133	494	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	265	133	494	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 1/26/2015 1:09 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	6,707,219	0	6,707,219	302,670.33	22.16	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		568,140	0	568,140	8,902.02	63.82	5.00
6.00	Non-physician-Part B		189,368	0	189,368	11,784.25	16.07	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		708,627	18,886	727,513	22,457.95	32.39	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		298,814	0	298,814	5,755.71	51.92	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		316,462	0	316,462	3,513.00	90.08	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,555,719	0	1,555,719			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		156,263	0	156,263			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		94,445	0	94,445			23.00
24.00	Wage-related costs (RHC/FQHC)		62,635	0	62,635			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	58,172	0	58,172	2,098.00	27.73	26.00
27.00	Administrative & General	5.00	850,852	0	850,852	40,699.86	20.91	27.00
28.00	Administrative & General under contract (see inst.)		80,666	0	80,666	418.00	192.98	28.00
29.00	Maintenance & Repairs	6.00	292,175	0	292,175	14,083.50	20.75	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	45,602	0	45,602	4,511.12	10.11	31.00
32.00	Housekeeping	9.00	142,670	-18,886	123,784	12,660.49	9.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	206,999	-155,975	51,024	4,621.08	11.04	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	155,975	155,975	14,126.19	11.04	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	426,246	0	426,246	14,286.46	29.84	38.00
39.00	Central Services and Supply	14.00	117,440	0	117,440	7,295.72	16.10	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 1/26/2015 1:09 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	219,797	0	219,797	14,972.29	14.68	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 1/26/2015 1:09 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		6,030,377	0	6,030,377	282,402.06	21.35	1.00
2.00	Excluded area salaries (see instructions)		708,627	18,886	727,513	22,457.95	32.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,321,750	-18,886	5,302,864	259,944.11	20.40	3.00
4.00	Subtotal other wages & related costs (see inst.)		615,276	0	615,276	9,268.71	66.38	4.00
5.00	Subtotal wage-related costs (see inst.)		1,555,719	0	1,555,719	0.00	29.34	5.00
6.00	Total (sum of lines 3 thru 5)		7,492,745	-18,886	7,473,859	269,212.82	27.76	6.00
7.00	Total overhead cost (see instructions)		2,440,619	-18,886	2,421,733	129,772.71	18.66	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 1/26/2015 1:09 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	196,299	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	23,473	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,046,760	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,273	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	18,782	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	99,955	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	448,780	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,740	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,869,062	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	309,339	0	1.00
2.00	Hospital	298,814	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	10,525	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140019 | Component CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-4 | Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

		1.00	
0.00	County	SHELBY	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	722	0	48	770	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	150.00	10.00	37.00	197.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.91	0.00	0.91	5.00
6.00	Direct Nursing Service		4.45	0.00	4.45	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.42	0.00	0.42	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.20	0.00	0.20	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.37	0.00	0.37	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	953	158	86	48	1,245	21.00
22.00	Skilled Nursing Visit Charges	134,550	24,178	9,420	6,751	174,899	22.00
23.00	Physical Therapy Visits	575	36	17	15	643	23.00
24.00	Physical Therapy Visit Charges	94,734	5,985	2,565	2,565	105,849	24.00
25.00	Occupational Therapy Visits	228	32	1	0	261	25.00
26.00	Occupational Therapy Visit Charges	45,854	6,464	202	0	52,520	26.00
27.00	Speech Pathology Visits	17	0	0	0	17	27.00
28.00	Speech Pathology Visit Charges	3,230	0	0	0	3,230	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	295	63	1	8	367	31.00
32.00	Home Health Aide Visit Charges	23,862	5,166	82	656	29,766	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,068	289	105	71	2,533	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	302,230	41,793	12,269	9,972	366,264	35.00
36.00	Total Number of Episodes (standard/non outlier)	121		28	5	154	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	3,129	263	413	185	3,990	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-7 | Date/Time Prepared: 1/26/2015 1:09 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/13/1993	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	7	7	20.00
21.00		RMC	0	7	7	21.00
22.00		RMB	0	9	9	22.00
23.00		RMA	0	6	6	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	22	22	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	11	11	30.00
31.00		HD2	0	8	8	31.00
32.00		HD1	0	38	38	32.00
33.00		HC2	0	6	6	33.00
34.00		HC1	0	41	41	34.00
35.00		HB2	0	3	3	35.00
36.00		HB1	0	47	47	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	4	4	47.00
48.00		CD1	0	5	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	9	9	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	12	12	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	104	104	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-7 | Date/Time Prepared: 1/26/2015 1:09 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	2	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	341	341	200.00

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

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

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2013 To 08/31/2014 | Worksheet S-8 | Date/Time Prepared: 1/26/2015 1:09 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			200 SOUTH CEDAR STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	SHELBYVILLE		IL	62565	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			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.			N	0	13.00

			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				14.00

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

			County				
			4.00				
2.00	City, State, Zip Code, County		SHELBY				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	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2013 To 08/31/2014	Worksheet S-8 Date/Time Prepared: 1/26/2015 1:09 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet S-10 Date/Time Prepared: 1/26/2015 1:09 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.473822	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	691,826	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	0	5.00
6.00	Medicaid charges	4,009,801	6.00
7.00	Medicaid cost (line 1 times line 6)	1,899,932	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)	1,208,106	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,208,106	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	375,031	213,544	588,575	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	177,698	101,182	278,880	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	177,698	101,182	278,880	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,466,910	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	96,234	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,370,676	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	649,456	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	928,336	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,136,442	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,319,121	1,319,121	-81,468	1,237,653	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	672,991	672,991	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	58,172	1,752,723	1,810,895	122,468	1,933,363	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	850,852	1,955,815	2,806,667	-316,587	2,490,080	5.00
6.00	00600	MAINTENANCE & REPAIRS	292,175	67,110	359,285	-165	359,120	6.00
7.00	00700	OPERATION OF PLANT	0	274,204	274,204	-43,414	230,790	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,602	28,222	73,824	0	73,824	8.00
9.00	00900	HOUSEKEEPING	142,670	10,949	153,619	-18,886	134,733	9.00
10.00	01000	DIETARY	206,999	238,022	445,021	-335,326	109,695	10.00
11.00	01100	CAFETERIA	0	0	0	335,326	335,326	11.00
13.00	01300	NURSING ADMINISTRATION	426,246	40,305	466,551	0	466,551	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,440	19,756	137,196	-218	136,978	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,797	22,630	242,427	0	242,427	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	87,588	87,588	0	87,588	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	697,911	304,507	1,002,418	0	1,002,418	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,921	122,792	242,713	-67,230	175,483	50.00
53.00	05300	ANESTHESIOLOGY	0	950	950	0	950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	411,113	392,767	803,880	0	803,880	54.00
60.00	06000	LABORATORY	395,337	729,722	1,125,059	0	1,125,059	60.00
65.00	06500	RESPIRATORY THERAPY	165,105	66,443	231,548	-43,478	188,070	65.00
66.00	06600	PHYSICAL THERAPY	376,645	29,660	406,305	-305	406,000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,692	28,692	42,975	71,667	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	973,092	973,092	4,059	977,151	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	44,338	986	45,324	0	45,324	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	757,508	63,420	820,928	51,617	872,545	88.00
90.00	09000	CLINIC	130,167	18,829	148,996	-4,754	144,242	90.00
91.00	09100	EMERGENCY	436,987	836,380	1,273,367	0	1,273,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	103,607	38,030	141,637	-5,025	136,612	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	380,740	62,773	443,513	-8,608	434,905	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		402,113	402,113	-402,113	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,379,332	9,887,601	16,266,933	-98,141	16,168,792	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	327,887	5,605	333,492	79,717	413,209	192.00
194.00	07950	FARM EXPENSES	0	0	0	18,424	18,424	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,707,219	9,893,206	16,600,425	0	16,600,425	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-402,113	835,540		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	672,991		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-296,001	1,637,362		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-631,196	1,858,884		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	359,120		6.00
7.00	00700	OPERATION OF PLANT	0	230,790		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64	73,888		8.00
9.00	00900	HOUSEKEEPING	0	134,733		9.00
10.00	01000	DIETARY	0	109,695		10.00
11.00	01100	CAFETERIA	-67,107	268,219		11.00
13.00	01300	NURSING ADMINISTRATION	0	466,551		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,687	133,291		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,915	236,512		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-87,588	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-44,105	958,313		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	175,483		50.00
53.00	05300	ANESTHESIOLOGY	0	950		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	803,880		54.00
60.00	06000	LABORATORY	-35	1,125,024		60.00
65.00	06500	RESPIRATORY THERAPY	-13,157	174,913		65.00
66.00	06600	PHYSICAL THERAPY	0	406,000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,457	70,210		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	977,151		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-6,091	39,233		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-1,180	871,365		88.00
90.00	09000	CLINIC	-2,197	142,045		90.00
91.00	09100	EMERGENCY	-519,223	754,144		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-11	136,601		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	-34,803	400,102		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,115,802	14,052,990		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	413,209		192.00
194.00	07950	FARM EXPENSES	0	18,424		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,115,802	14,484,623		200.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-6 | Date/Time Prepared: 1/26/2015 1:09 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL CENTER RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	18,886	0	1.00
	TOTALS		18,886	0	
	B - FIRE INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	32,194	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,305	2.00
	TOTALS		0	33,499	
	C - TELEPHONE EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,250	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	8,250	
	D - WORKER'S COMPENSATION INS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	98,995	1.00
	TOTALS		0	98,995	
	E - RENTAL EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	115,944	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	115,944	
	F - MEDICAL CENTER UTILITLES RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,414	1.00
	TOTALS		0	43,414	
	G - PHYSICIAN BUILDING DEPR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,112	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	16,112	
	H - DEPRECIATION EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	520,183	1.00
	TOTALS		0	520,183	
	I - PROPERTY INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	42,164	1.00
	TOTALS		0	42,164	
	J - CAFETERIA EXPENSE RECLASS				
1.00	CAFETERIA	11.00	155,975	179,351	1.00
	TOTALS		155,975	179,351	
	K - REAL ESTATE TAX RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	15,220	1.00
2.00	FARM EXPENSES	194.00	0	18,424	2.00
	TOTALS		0	33,644	
	L - ONCOLOGY PHARMACY COSTS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,745	1.00
	TOTALS		0	4,745	
	M - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	402,113	1.00
	TOTALS		0	402,113	
	N - MEDICAL SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,975	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	42,975	
	O - PENSION AUDIT COSTS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,473	1.00
	TOTALS		0	23,473	
	P - RHC PHYSICIAN RECRUITMENT				
1.00	RURAL HEALTH CLINIC	88.00	0	54,966	1.00
	TOTALS		0	54,966	
500.00	Grand Total: Increases		174,861	1,619,828	500.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-6 | Date/Time Prepared: 1/26/2015 1:09 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL CENTER RECLASS						
1.00	HOUSEKEEPING	9.00	18,886	0	0		1.00
	TOTALS		18,886	0			
	B - FIRE INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,499	5		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	33,499			
	C - TELEPHONE EXPENSE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	218	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	305	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	686	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	3,349	0		4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	9	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	3,683	0		6.00
	TOTALS		0	8,250			
	D - WORKER'S COMPENSATION INS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	98,995	0		1.00
	TOTALS		0	98,995			
	E - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38,096	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	165	0		2.00
3.00	OPERATING ROOM	50.00	0	67,230	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	512	0		4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	5,016	0		5.00
6.00	HOME HEALTH AGENCY	101.00	0	4,925	0		6.00
	TOTALS		0	115,944			
	F - MEDICAL CENTER UTILITLES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	43,414	0		1.00
	TOTALS		0	43,414			
	G - PHYSICIAN BUILDING DEPR RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,060	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,052	9		2.00
	TOTALS		0	16,112			
	H - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	520,183	9		1.00
	TOTALS		0	520,183			
	I - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,164	5		1.00
	TOTALS		0	42,164			
	J - CAFETERIA EXPENSE RECLASS						
1.00	DIETARY	10.00	155,975	179,351	0		1.00
	TOTALS		155,975	179,351			
	K - REAL ESTATE TAX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,644	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	33,644			
	L - ONCOLOGY PHARMACY COSTS RECLASS						
1.00	CLINIC	90.00	0	4,745	0		1.00
	TOTALS		0	4,745			
	M - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	402,113	11		1.00
	TOTALS		0	402,113			
	N - MEDICAL SUPPLIES RECLASS						
1.00	RESPIRATORY THERAPY	65.00	0	42,966	0		1.00
2.00	CLINIC	90.00	0	9	0		2.00
	TOTALS		0	42,975			
	O - PENSION AUDIT COSTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,473	0		1.00
	TOTALS		0	23,473			
	P - RHC PHYSICIAN RECRUITMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,966	0		1.00
	TOTALS		0	54,966			
500.00	Grand Total: Decreases		174,861	1,619,828			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	991,651	0	0	0	0	1.00
2.00	Land Improvements	245,904	10,004	0	10,004	0	2.00
3.00	Buildings and Fixtures	15,211,091	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,767,373	52,847	0	52,847	0	5.00
6.00	Movable Equipment	10,069,649	249,378	0	249,378	2,301	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,285,668	312,229	0	312,229	2,301	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,285,668	312,229	0	312,229	2,301	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	991,651	0	1.00
2.00	Land Improvements	255,908	0	2.00
3.00	Buildings and Fixtures	15,211,091	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,820,220	0	5.00
6.00	Movable Equipment	10,316,726	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,595,596	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,595,596	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,316,378	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,316,378	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	2,743	1,319,121	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	2,743	1,319,121	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,458,650	0	16,458,650	0.520916	38,734	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,136,946	0	15,136,946	0.479084	35,624	2.00
3.00	Total (sum of lines 1-2)	31,595,596	0	31,595,596	1.000000	74,358	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,928	0	46,662	786,135	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,292	0	42,916	514,131	115,944	2.00
3.00	Total (sum of lines 1-2)	15,220	0	89,578	1,300,266	115,944	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	38,734	7,928	2,743	835,540	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,624	7,292	0	672,991	2.00
3.00	Total (sum of lines 1-2)	0	74,358	15,220	2,743	1,508,531	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-8 | Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-402,113	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-3,687	CENTRAL SERVICES & SUPPLY	14.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-578,682			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	A	64	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,107	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	B	-1,457	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	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	-5,915	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-87,588	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		0		0.00	0	32.00
33.00	SELF INSURANCE EXPENSE	A	-295,811	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	ADVERTISING	A	-59,724	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-8 | Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS INCOME	B	-2,820	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NURSING SERVICES SOLD	B	-27,085	HOME HEALTH AGENCY	101.00	0	33.03
33.04	LIFELINE INCOME	B	-7,718	HOME HEALTH AGENCY	101.00	0	33.04
33.05	PROMOTIONAL ITEMS	A	-4,919	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	SWITCHBOARD SALARY EXPENSE	A	-684	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SWITCHBOARD BENEFIT EXPENSE	A	-190	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING DUES	A	-8,304	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	FRA TAX	A	-531,950	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROMOTIONAL ITEMS	A	-1,180	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	INVESTMENT INCOME OFFSET	B	-35	LABORATORY	60.00	0	33.12
33.13	DEPOSITION INCOME	B	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	DME MISCELLANEOUS INCOME	B	-11	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.14
33.15	WELLNESS FOR LIFE REVENUE	B	-6,091	CARDIAC REHABILITATION	76.97	0	33.15
33.16	FOUNDATION AND FUNDRAISING EXPENSES	A	-18,590	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,115,802				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 1/26/2015 1:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	44,105	44,105	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	13,157	13,157	0	0	0	2.00
3.00	90.00	CLINIC	2,197	2,197	0	0	0	3.00
4.00	91.00	EMERGENCY	789,116	472,654	316,462	159,800	3,513	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			848,575	532,113	316,462		3,513	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	269,893	13,495	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			269,893	13,495	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	44,105		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	13,157		2.00
3.00	90.00	CLINIC	0	0	0	2,197		3.00
4.00	91.00	EMERGENCY	0	269,893	46,569	519,223		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	269,893	46,569	578,682		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	835,540	835,540				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	672,991		672,991			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,637,362	9,460	7,620	1,654,442		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,858,884	100,087	80,616	211,563	2,251,150	5.00
6.00	00600	MAINTENANCE & REPAIRS	359,120	20,121	16,206	72,708	468,155	6.00
7.00	00700	OPERATION OF PLANT	230,790	19,358	15,592	0	265,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,888	16,911	13,621	11,348	115,768	8.00
9.00	00900	HOUSEKEEPING	134,733	8,035	6,472	30,804	180,044	9.00
10.00	01000	DIETARY	109,695	25,597	20,617	12,697	168,606	10.00
11.00	01100	CAFETERIA	268,219	8,977	7,231	38,814	323,241	11.00
13.00	01300	NURSING ADMINISTRATION	466,551	7,721	6,219	106,071	586,562	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,291	43,900	35,359	29,225	241,775	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	236,512	19,728	15,890	54,696	326,826	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	958,313	120,857	97,345	173,675	1,350,190	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,483	68,554	55,217	29,842	329,096	50.00
53.00	05300	ANESTHESIOLOGY	950	1,347	1,085	0	3,382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	803,880	59,240	47,715	102,305	1,013,140	54.00
60.00	06000	LABORATORY	1,125,024	23,420	18,864	98,380	1,265,688	60.00
65.00	06500	RESPIRATORY THERAPY	174,913	16,518	13,305	41,086	245,822	65.00
66.00	06600	PHYSICAL THERAPY	406,000	43,260	34,844	93,728	577,832	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,210	0	0	0	70,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	977,151	8,865	7,141	0	993,157	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,233	16,025	12,907	11,034	79,199	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	871,365	54,044	43,530	188,506	1,157,445	88.00
90.00	09000	CLINIC	142,045	86,834	69,941	32,392	331,212	90.00
91.00	09100	EMERGENCY	754,144	22,488	18,113	108,744	903,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	136,601	20,020	16,125	25,783	198,529	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	400,102	14,173	11,416	94,747	520,438	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,052,990	835,540	672,991	1,568,148	13,966,696	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	413,209	0	0	86,294	499,503	192.00
194.00	07950	FARM EXPENSES	18,424	0	0	0	18,424	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,484,623	835,540	672,991	1,654,442	14,484,623	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,251,150					5.00
6.00	00600	MAINTENANCE & REPAIRS	86,148	554,303				6.00
7.00	00700	OPERATION OF PLANT	48,900	15,201	329,841			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,303	13,280	8,125	158,476		8.00
9.00	00900	HOUSEKEEPING	33,131	6,310	3,860	0	223,345	9.00
10.00	01000	DIETARY	31,026	20,101	12,298	0	8,641	10.00
11.00	01100	CAFETERIA	59,482	7,050	4,313	0	3,031	11.00
13.00	01300	NURSING ADMINISTRATION	107,937	6,063	3,709	0	2,606	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	44,490	34,473	21,092	1,537	14,820	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,141	15,492	9,478	0	6,660	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	248,453	94,904	58,069	79,236	40,801	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,559	53,834	32,937	0	23,144	50.00
53.00	05300	ANESTHESIOLOGY	622	1,057	647	0	455	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,434	46,519	28,462	27,206	19,999	54.00
60.00	06000	LABORATORY	232,907	18,391	11,252	19	7,907	60.00
65.00	06500	RESPIRATORY THERAPY	45,235	12,972	7,936	12,927	5,577	65.00
66.00	06600	PHYSICAL THERAPY	106,330	33,971	20,785	0	14,605	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,920	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	182,757	6,962	4,259	0	2,993	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,574	12,584	7,699	0	5,410	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	212,988	42,439	25,966	343	18,245	88.00
90.00	09000	CLINIC	60,948	68,189	41,720	21	29,315	90.00
91.00	09100	EMERGENCY	166,256	17,660	10,805	37,187	7,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	36,533	15,721	9,619	0	6,759	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	95,769	11,130	6,810	0	4,785	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,155,843	554,303	329,841	158,476	223,345	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	91,917	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	3,390	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,251,150	554,303	329,841	158,476	223,345	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	240,672					10.00
11.00	01100	CAFETERIA	0	397,117				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,034	733,911			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,806	17,973	389,966		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,330	0	3,558	450,485	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	240,672	67,149	347,619	0	162,884	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,313	42,612	0	4,280	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,349	0	11,527	111,206	54.00
60.00	06000	LABORATORY	0	37,415	0	298,432	32,081	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,605	109,602	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	26,453	0	0	10,682	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	40,152	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	21,266	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,544	16,215	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	39,142	0	6,896	73,749	88.00
90.00	09000	CLINIC	0	12,534	57,346	4,664	0	90.00
91.00	09100	EMERGENCY	0	30,120	142,544	0	55,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	13,828	0	3,471	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	28,968	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	240,672	383,590	733,911	389,966	450,485	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	13,527	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	240,672	397,117	733,911	389,966	450,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part I | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,689,977	0	2,689,977		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	555,775	0	555,775		50.00
53.00	05300	ANESTHESIOLOGY	0	6,163	0	6,163		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,474,842	0	1,474,842		54.00
60.00	06000	LABORATORY	0	1,904,092	0	1,904,092		60.00
65.00	06500	RESPIRATORY THERAPY	0	455,676	0	455,676		65.00
66.00	06600	PHYSICAL THERAPY	0	790,658	0	790,658		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	123,282	0	123,282		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,211,394	0	1,211,394		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	139,225	0	139,225		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,577,213	0	1,577,213		88.00
90.00	09000	CLINIC	0	605,949	0	605,949		90.00
91.00	09100	EMERGENCY	0	1,371,256	0	1,371,256		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	284,460	0	284,460		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	667,900	0	667,900		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	13,857,862	0	13,857,862		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	604,947	0	604,947		192.00
194.00	07950	FARM EXPENSES	0	21,814	0	21,814		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	14,484,623	0	14,484,623		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part II | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,460	7,620	17,080	17,080	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	100,087	80,616	180,703	2,183	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	20,121	16,206	36,327	751	6.00
7.00	00700	OPERATION OF PLANT	0	19,358	15,592	34,950	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,911	13,621	30,532	117	8.00
9.00	00900	HOUSEKEEPING	0	8,035	6,472	14,507	318	9.00
10.00	01000	DIETARY	0	25,597	20,617	46,214	131	10.00
11.00	01100	CAFETERIA	0	8,977	7,231	16,208	401	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,721	6,219	13,940	1,095	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,900	35,359	79,259	302	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,728	15,890	35,618	565	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	120,857	97,345	218,202	1,793	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,554	55,217	123,771	308	50.00
53.00	05300	ANESTHESIOLOGY	0	1,347	1,085	2,432	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,240	47,715	106,955	1,056	54.00
60.00	06000	LABORATORY	0	23,420	18,864	42,284	1,016	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,518	13,305	29,823	424	65.00
66.00	06600	PHYSICAL THERAPY	0	43,260	34,844	78,104	968	66.00
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	8,865	7,141	16,006	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,025	12,907	28,932	114	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	54,044	43,530	97,574	1,946	88.00
90.00	09000	CLINIC	0	86,834	69,941	156,775	334	90.00
91.00	09100	EMERGENCY	0	22,488	18,113	40,601	1,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	20,020	16,125	36,145	266	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	14,173	11,416	25,589	978	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	835,540	672,991	1,508,531	16,189	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	17,417	0	0	17,417	891	192.00
194.00	07950	FARM EXPENSES	18,424	0	0	18,424	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	35,841	835,540	672,991	1,544,372	17,080	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part II | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	182,886					5.00
6.00	00600	MAINTENANCE & REPAIRS	6,999	44,077				6.00
7.00	00700	OPERATION OF PLANT	3,973	1,209	40,132			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,731	1,056	989	34,425		8.00
9.00	00900	HOUSEKEEPING	2,692	502	470	0	18,489	9.00
10.00	01000	DIETARY	2,521	1,598	1,496	0	715	10.00
11.00	01100	CAFETERIA	4,832	561	525	0	251	11.00
13.00	01300	NURSING ADMINISTRATION	8,769	482	451	0	216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,615	2,741	2,566	334	1,227	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,886	1,232	1,153	0	551	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,178	7,547	7,065	17,211	3,377	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,920	4,281	4,007	0	1,916	50.00
53.00	05300	ANESTHESIOLOGY	51	84	79	0	38	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,146	3,699	3,463	5,910	1,656	54.00
60.00	06000	LABORATORY	18,922	1,462	1,369	4	655	60.00
65.00	06500	RESPIRATORY THERAPY	3,675	1,031	966	2,808	462	65.00
66.00	06600	PHYSICAL THERAPY	8,639	2,701	2,529	0	1,209	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,050	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	14,848	554	518	0	248	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,184	1,001	937	0	448	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,304	3,375	3,159	75	1,510	88.00
90.00	09000	CLINIC	4,952	5,422	5,076	5	2,427	90.00
91.00	09100	EMERGENCY	13,507	1,404	1,315	8,078	628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,968	1,250	1,170	0	559	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	7,781	885	829	0	396	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	175,143	44,077	40,132	34,425	18,489	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	7,468	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	275	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	182,886	44,077	40,132	34,425	18,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part II | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	52,675					10.00
11.00	01100	CAFETERIA	0	22,778				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,551	26,504			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	792	649	91,485		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,625	0	835	46,465	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,675	3,851	12,553	0	16,801	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	534	1,539	0	441	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,741	0	2,704	11,470	54.00
60.00	06000	LABORATORY	0	2,146	0	70,011	3,309	60.00
65.00	06500	RESPIRATORY THERAPY	0	895	3,958	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,517	0	0	1,102	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,420	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	4,989	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	203	586	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,245	0	1,618	7,607	88.00
90.00	09000	CLINIC	0	719	2,071	1,094	0	90.00
91.00	09100	EMERGENCY	0	1,728	5,148	0	5,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	793	0	814	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,662	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,675	22,002	26,504	91,485	46,465	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	776	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	52,675	22,778	26,504	91,485	46,465	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B Part II | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		361,253	0	361,253		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		141,717	0	141,717		50.00
53.00	05300	ANESTHESIOLOGY		2,684	0	2,684		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		153,800	0	153,800		54.00
60.00	06000	LABORATORY		141,178	0	141,178		60.00
65.00	06500	RESPIRATORY THERAPY		44,042	0	44,042		65.00
66.00	06600	PHYSICAL THERAPY		96,769	0	96,769		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		10,470	0	10,470		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		37,163	0	37,163		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		33,405	0	33,405		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		136,413	0	136,413		88.00
90.00	09000	CLINIC		178,875	0	178,875		90.00
91.00	09100	EMERGENCY		79,267	0	79,267		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		43,965	0	43,965		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY		38,120	0	38,120		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,499,121	0	1,499,121		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		26,552	0	26,552		192.00
194.00	07950	FARM EXPENSES		18,699	0	18,699		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,544,372	0	1,544,372		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B-1 | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	843	843	6,648,363			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	850,168	-2,251,150	12,233,473	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	292,175	0	468,155	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	265,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	45,602	0	115,768	8.00
9.00	00900	HOUSEKEEPING	716	716	123,784	0	180,044	9.00
10.00	01000	DIETARY	2,281	2,281	51,024	0	168,606	10.00
11.00	01100	CAFETERIA	800	800	155,975	0	323,241	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	426,246	0	586,562	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	117,440	0	241,775	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	219,797	0	326,826	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	697,911	0	1,350,190	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	119,921	0	329,096	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	0	3,382	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	411,113	0	1,013,140	54.00
60.00	06000	LABORATORY	2,087	2,087	395,337	0	1,265,688	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	165,105	0	245,822	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	376,645	0	577,832	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	70,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	0	993,157	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	44,338	0	79,199	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	757,508	0	1,157,445	88.00
90.00	09000	CLINIC	7,738	7,738	130,167	0	331,212	90.00
91.00	09100	EMERGENCY	2,004	2,004	436,987	0	903,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	103,607	0	198,529	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	380,740	0	520,438	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,457	74,457	6,301,590	-2,251,150	11,715,546	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	346,773	0	499,503	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	18,424	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	835,540	672,991	1,654,442		2,251,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.221779	9.038653	0.248850		0.184016	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,080		182,886	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002569		0.014950	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B-1 | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	75,703			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	8,647	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	734	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	37,851	10,770	8,647	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,109	6,109	0	6,109	0	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	12,996	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	9	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	6,175	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	0	3,855	0	66.00
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	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	164	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	10	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	17,764	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,902	61,177	75,703	58,954	8,647	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	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	554,303	329,841	158,476	223,345	240,672	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.812168	5.391585	2.093391	3.788462	27.833006	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,077	40,132	34,425	18,489	52,675	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.700725	0.655998	0.454738	0.313617	6.091708	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet B-1 | Date/Time Prepared: 1/26/2015 1:09 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	209,870					11.00
13.00	01300	NURSING ADMINISTRATION	14,287	84,773				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,296	2,076	696,046			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,972	0	6,350	12,736		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,487	40,153	0	4,605		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,922	4,922	0	121	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,039	0	20,575	3,144	0	54.00
60.00	06000	LABORATORY	19,773	0	532,669	907	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,247	12,660	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,980	0	0	302	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71,667	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	37,958	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,873	1,873	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,686	0	12,308	2,085	0	88.00
90.00	09000	CLINIC	6,624	6,624	8,324	0	0	90.00
91.00	09100	EMERGENCY	15,918	16,465	0	1,572	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	7,308	0	6,195	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	15,309	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	202,721	84,773	696,046	12,736	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	7,149	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	397,117	733,911	389,966	450,485	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.892205	8.657367	0.560259	35.370996	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,778	26,504	91,485	46,465	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.108534	0.312647	0.131435	3.648320	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet C Part I Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,689,977		2,689,977	0	2,689,977	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	555,775		555,775	0	555,775	50.00
53.00	05300	ANESTHESIOLOGY	6,163		6,163	0	6,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,474,842		1,474,842	0	1,474,842	54.00
60.00	06000	LABORATORY	1,904,092		1,904,092	0	1,904,092	60.00
65.00	06500	RESPIRATORY THERAPY	455,676	0	455,676	0	455,676	65.00
66.00	06600	PHYSICAL THERAPY	790,658	0	790,658	0	790,658	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123,282		123,282	0	123,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,211,394		1,211,394	0	1,211,394	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	139,225		139,225	0	139,225	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,577,213		1,577,213	0	1,577,213	88.00
90.00	09000	CLINIC	605,949		605,949	0	605,949	90.00
91.00	09100	EMERGENCY	1,371,256		1,371,256	46,569	1,417,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	597,462		597,462		597,462	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	284,460		284,460	0	284,460	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	667,900		667,900		667,900	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,455,324	0	14,455,324	46,569	14,501,893	200.00
201.00		Less Observation Beds	597,462		597,462		597,462	201.00
202.00		Total (see instructions)	13,857,862	0	13,857,862	46,569	13,904,431	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet C Part I Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,520,752		2,520,752			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,408	939,271	942,679	0.589570	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	3,039	364,427	367,466	0.016772	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	574,458	7,961,134	8,535,592	0.172787	0.000000	54.00
60.00	06000	LABORATORY	879,800	6,275,902	7,155,702	0.266094	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	208,321	1,239,127	1,447,448	0.314813	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	112,166	1,088,047	1,200,213	0.658765	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	285,517	188,620	474,137	0.260013	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,279	822,078	1,282,357	0.944662	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	86,560	86,560	1.608422	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	695,445	695,445			88.00
90.00	09000	CLINIC	4,594	626,032	630,626	0.960869	0.000000	90.00
91.00	09100	EMERGENCY	105,902	2,182,987	2,288,889	0.599092	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	123,741	546,689	670,430	0.891162	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	296,135	296,135	0.960575	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	652,534	652,534			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,281,977	23,964,988	29,246,965			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,281,977	23,964,988	29,246,965			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet C Part I Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.589570
53.00	05300	ANESTHESIOLOGY	0.016772
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172787
60.00	06000	LABORATORY	0.266094
65.00	06500	RESPIRATORY THERAPY	0.314813
66.00	06600	PHYSICAL THERAPY	0.658765
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260013
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.944662
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000
76.97	07697	CARDIAC REHABILITATION	1.608422
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
90.00	09000	CLINIC	0.960869
91.00	09100	EMERGENCY	0.619438
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.891162
		OTHER REIMBURSABLE COST CENTERS	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.960575
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part I Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	361,253	0	361,253	1,927	187.47	30.00
200.00	Total (lines 30-199)	361,253		361,253	1,927		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	850	159,350	30.00
200.00	Total (lines 30-199)	850	159,350	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part II Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,717	942,679	0.150334	1,236	186	50.00
53.00	05300	ANESTHESIOLOGY	2,684	367,466	0.007304	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,800	8,535,592	0.018019	522,744	9,419	54.00
60.00	06000	LABORATORY	141,178	7,155,702	0.019729	742,910	14,657	60.00
65.00	06500	RESPIRATORY THERAPY	44,042	1,447,448	0.030427	151,649	4,614	65.00
66.00	06600	PHYSICAL THERAPY	96,769	1,200,213	0.080627	42,204	3,403	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,470	474,137	0.022082	200,661	4,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,163	1,282,357	0.028980	276,594	8,016	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,405	86,560	0.385917	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	136,413	695,445	0.196152	0	0	88.00
90.00	09000	CLINIC	178,875	630,626	0.283647	638	181	90.00
91.00	09100	EMERGENCY	79,267	2,288,889	0.034631	81,848	2,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	80,237	670,430	0.119680	83,113	9,947	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	43,965	296,135	0.148463	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,179,985	26,073,679		2,103,597	57,688	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part III Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	1,927	0.00	850	0		30.00
200.00		Total (lines 30-199)	1,927		850	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part IV Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		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
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part IV Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	942,679	0.000000	0.000000	1,236	50.00
53.00	05300	ANESTHESIOLOGY	0	367,466	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,535,592	0.000000	0.000000	522,744	54.00
60.00	06000	LABORATORY	0	7,155,702	0.000000	0.000000	742,910	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,447,448	0.000000	0.000000	151,649	65.00
66.00	06600	PHYSICAL THERAPY	0	1,200,213	0.000000	0.000000	42,204	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	474,137	0.000000	0.000000	200,661	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	1,282,357	0.000000	0.000000	276,594	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	86,560	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	695,445	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	630,626	0.000000	0.000000	638	90.00
91.00	09100	EMERGENCY	0	2,288,889	0.000000	0.000000	81,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	670,430	0.000000	0.000000	83,113	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	296,135	0.000000	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	26,073,679			2,103,597	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part IV | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	541,539	0		50.00
53.00	05300	ANESTHESIOLOGY	0	208,484	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,628,023	0		54.00
60.00	06000	LABORATORY	0	877,249	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	641,093	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	114,517	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	771,652	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	33,988	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	41,863	0		90.00
91.00	09100	EMERGENCY	0	668,018	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	248,090	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	7,774,516	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part V Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.589570	541,539	0	0	319,275	50.00
53.00	05300	ANESTHESIOLOGY	0.016772	208,484	0	0	3,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172787	3,628,023	0	0	626,875	54.00
60.00	06000	LABORATORY	0.266094	877,249	0	0	233,431	60.00
65.00	06500	RESPIRATORY THERAPY	0.314813	641,093	0	0	201,824	65.00
66.00	06600	PHYSICAL THERAPY	0.658765	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260013	114,517	0	0	29,776	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.944662	771,652	0	1,874	728,950	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.608422	33,988	0	0	54,667	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.960869	41,863	0	0	40,225	90.00
91.00	09100	EMERGENCY	0.599092	668,018	0	0	400,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.891162	248,090	0	0	221,088	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.960575	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		7,774,516	0	1,874	2,859,812	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		7,774,516	0	1,874	2,859,812	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D Part V Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	1,770		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	1,770		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,770		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D-1 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,325	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,927	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)	1,499	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)	341	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	57	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	850	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	341	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,689,977	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,689,977	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)	2,689,977	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)	1,395.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,186,549	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)	1,186,549	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D-1 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	803,122	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,989,671	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)	159,350	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	57,688	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	217,038	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,772,633	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)	428	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,395.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	597,462	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D-1 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | 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	361,253	2,689,977	0.134296	597,462	80,237	90.00
91.00	Nursing School cost	0	2,689,977	0.000000	597,462	0	91.00
92.00	Allied health cost	0	2,689,977	0.000000	597,462	0	92.00
93.00	All other Medical Education	0	2,689,977	0.000000	597,462	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D-3 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,360,705		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589570	1,236	729	50.00
53.00	05300	ANESTHESIOLOGY	0.016772	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172787	522,744	90,323	54.00
60.00	06000	LABORATORY	0.266094	742,910	197,684	60.00
65.00	06500	RESPIRATORY THERAPY	0.314813	151,649	47,741	65.00
66.00	06600	PHYSICAL THERAPY	0.658765	42,204	27,803	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260013	200,661	52,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.944662	276,594	261,288	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.608422	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.960869	638	613	90.00
91.00	09100	EMERGENCY	0.619438	81,848	50,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.891162	83,113	74,067	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.960575	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		2,103,597	803,122	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)		2,103,597		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet D-3 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589570	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.016772	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.172787	35,956	6,213	54.00
60.00	06000	LABORATORY	0.266094	110,717	29,461	60.00
65.00	06500	RESPIRATORY THERAPY	0.314813	50,760	15,980	65.00
66.00	06600	PHYSICAL THERAPY	0.658765	56,835	37,441	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260013	72,168	18,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.944662	102,919	97,224	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.608422	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.960869	0	0	90.00
91.00	09100	EMERGENCY	0.599092	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.891162	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.960575	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		429,355	205,084	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)		429,355		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E Part A Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		88,778			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,122,289			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		0			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		27.74			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.53			30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.73			31.00
32.00	Sum of lines 30 and 31		27.26			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E Part A Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		11.70			33.00
34.00	Disproportionate share adjustment (see instructions)		43,214			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)				9,046,380,143	35.00
35.01	Factor 3 (see instructions)				0.000012051	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				109,014	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				100,054	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		100,054			36.00
	Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		1,354,335			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		1,489,465			48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		1,489,465			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		95,320			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,584,785			59.00
60.00	Primary payer payments		1,188			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,583,597			61.00
62.00	Deductibles billed to program beneficiaries		208,416			62.00
63.00	Coinsurance billed to program beneficiaries		2,368			63.00
64.00	Allowable bad debts (see instructions)		47,532			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		30,896			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet E Part A Date/Time Prepared: 1/26/2015 1:09 pm
	Title XVIII	Hospital	PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,532			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,403,709			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		0			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-6,719			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2013	24,280			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2014	297,067			70.97
70.98	Low Volume Payment-3		0			70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,718,337			71.00
71.01	Sequestration adjustment (see instructions)		34,367			71.01
72.00	Interim payments		1,784,733			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-100,763			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	88,778	0	88,778	0	88,778	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	1,122,289	0	0	1,122,289	1,122,289	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1170	0.1170	0.1170	0.1170		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	43,214	0	10,387	32,827	43,214	11.00
11.01	Uncompensated care payments	36.00	100,054	0	0	100,054	100,054	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,354,335	0	99,165	1,255,170	1,354,335	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	1,489,465	0	122,669	1,366,796	1,489,465	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	1,489,465	0	122,669	1,366,796	1,489,465	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	95,320	0	7,943	87,377	95,320	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	130,612	1,454,173	1,584,785	19.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	95,320	0	7,943	87,377	95,320	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	95,320	0	7,943	87,377	95,320	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.185893	0.204286		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			24,280		24,280	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				297,067	297,067	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet E Part B Date/Time Prepared: 1/26/2015 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,770	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,859,812	2.00
3.00	PPS payments	1,704,097	3.00
4.00	Outlier payment (see instructions)	3,158	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,770	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,874	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)	1,874	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)	1,874	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	104	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,770	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,707,255	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	418,282	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)	1,290,743	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)	1,290,743	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,290,743	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)	82,067	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	53,344	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,067	36.00
37.00	Subtotal (see instructions)	1,344,087	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,344,087	40.00
40.01	Sequestration adjustment (see instructions)	26,882	40.01
41.00	Interim payments	1,334,363	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-17,158	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	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: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,306,933		1,317,838	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	04/22/2014	16,525	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	04/22/2014	280,093		0	3.50
3.51		08/28/2014	242,107		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)		-522,200		16,525	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)		1,784,733		1,334,363	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		100,763		17,158	6.02
7.00	Total Medicare program liability (see instructions)		1,683,970		1,317,205	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: 140019 | Component CCN: 14U019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		77,212		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		77,212		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		77,212		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: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet E-1 Part II Date/Time Prepared: 1/26/2015 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	494	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	850	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,499	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	29,246,965	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	588,575	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	289,350	8.00
9.00	Sequestration adjustment amount (see instructions)	5,787	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	283,563	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)	283,563	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet E-2 | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	95,844	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)			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	341	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)	95,844	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	95,844	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)	95,844	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,056	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)	78,788	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	78,788	0	19.00
19.01	Sequestration adjustment (see instructions)	1,576	0	19.01
20.00	Interim payments	77,212	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	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet G | Date/Time Prepared: 1/26/2015 1:09 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	441,611	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,578,955	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,833,598	0	0	0	6.00
7.00	Inventory	195,343	0	0	0	7.00
8.00	Prepaid expenses	238,950	0	0	0	8.00
9.00	Other current assets	274,683	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)	3,895,944	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	991,652	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-371,496	0	0	0	14.00
15.00	Buildings	15,466,999	0	0	0	15.00
16.00	Accumulated depreciation	-9,019,638	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	4,820,220	0	0	0	19.00
20.00	Accumulated depreciation	-3,657,770	0	0	0	20.00
21.00	Automobiles and trucks	10,316,725	0	0	0	21.00
22.00	Accumulated depreciation	-8,410,890	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,135,802	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	21,773,835	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	213,130	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,986,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,018,711	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	365,238	0	0	0	37.00
38.00	Salaries, wages, and fees payable	562,795	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	300,000	0	0	0	40.00
41.00	Deferred income	0	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	410,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,638,033	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,800,000	0	0	0	46.00
47.00	Notes payable	81,002	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,881,002	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,519,035	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	26,499,676				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)	26,499,676	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,018,711	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet G-1 | Date/Time Prepared: 1/26/2015 1:09 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		26,610,010		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-110,334				2.00
3.00	Total (sum of line 1 and line 2)		26,499,676		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		26,499,676		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)		26,499,676		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			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: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/26/2015 1:09 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,129,377		2,129,377	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	412,480		412,480	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,541,857		2,541,857	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,541,857		2,541,857	17.00
18.00	Ancillary services	2,426,552	19,687,173	22,113,725	18.00
19.00	Outpatient services	235,278	3,375,654	3,610,932	19.00
20.00	RURAL HEALTH CLINIC	0	695,445	695,445	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		652,534	652,534	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	2,442	581,132	583,574	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,206,129	24,991,938	30,198,067	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,600,425		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,600,425		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet G-3 | Date/Time Prepared: 1/26/2015 1:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	30,198,067	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,304,607	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,893,460	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,600,425	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,706,965	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	72,598	6.00
7.00	Income from investments	2,849,529	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	67,043	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	1,457	17.00
18.00	Revenue from sale of medical records and abstracts	5,915	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	79,137	22.00
23.00	Governmental appropriations	0	23.00
24.00	DEPOSITION INCOME	500	24.00
24.01	FARM INCOME	147,932	24.01
24.02	GAIN ON SALE OF EQUIPMENT	2,887	24.02
24.03	LIFELINE INCOME	7,718	24.03
24.04	NURSING SERVICES	27,085	24.04
24.05	PROFESSIONAL FEES	3,250	24.05
24.06	MISCELLANEOUS INCOME	2,831	24.06
24.07	EHR INCENTIVE PAYMENT	322,658	24.07
24.08	WELLNESS FOR LIFE	6,091	24.08
25.00	Total other income (sum of lines 6-24)	3,596,631	25.00
26.00	Total (line 5 plus line 25)	-110,334	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)	-110,334	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H | Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	130,267	0	27,677	10,525	24,571	193,040	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	178,799	0	0	0	0	178,799	6.00
7.00	Physical Therapy	36,401	0	0	0	0	36,401	7.00
8.00	Occupational Therapy	17,024	0	0	0	0	17,024	8.00
9.00	Speech Pathology	1,862	0	0	0	0	1,862	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	16,387	0	0	0	0	16,387	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	380,740	0	27,677	10,525	24,571	443,513	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-8,608	184,432	-34,803	149,629			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	178,799	0	178,799			6.00
7.00	Physical Therapy	0	36,401	0	36,401			7.00
8.00	Occupational Therapy	0	17,024	0	17,024			8.00
9.00	Speech Pathology	0	1,862	0	1,862			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	16,387	0	16,387			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-8,608	434,905	-34,803	400,102			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-1 Part I Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	149,629	0	0	0	0	149,629	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	178,799	0	0	0	0	178,799	6.00
7.00	Physical Therapy	36,401	0	0	0	0	36,401	7.00
8.00	Occupational Therapy	17,024	0	0	0	0	17,024	8.00
9.00	Speech Pathology	1,862	0	0	0	0	1,862	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	16,387	0	0	0	0	16,387	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	400,102	0	0	0	0	400,102	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	149,629			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	106,813	285,612		6.00
7.00	Physical Therapy	21,745	58,146		7.00
8.00	Occupational Therapy	10,170	27,194		8.00
9.00	Speech Pathology	1,112	2,974		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	9,789	26,176		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		400,102		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2013 To 08/31/2014

Worksheet H-1 Part II Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I

PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-149,629	250,473	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	178,799	6.00
7.00	Physical Therapy	0	0	0	0	0	36,401	7.00
8.00	Occupational Therapy	0	0	0	0	0	17,024	8.00
9.00	Speech Pathology	0	0	0	0	0	1,862	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	16,387	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-149,629	250,473	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		149,629	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.597386	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	14,173	11,416	32,417	58,006	10,674	1.00
2.00	Skilled Nursing Care	285,612	0	0	44,495	330,107	60,745	2.00
3.00	Physical Therapy	58,146	0	0	9,058	67,204	12,367	3.00
4.00	Occupational Therapy	27,194	0	0	4,236	31,430	5,784	4.00
5.00	Speech Pathology	2,974	0	0	463	3,437	632	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	26,176	0	0	4,078	30,254	5,567	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	400,102	14,173	11,416	94,747	520,438	95,769	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	11,130	6,810	0	4,785	0	28,968	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	11,130	6,810	0	4,785	0	28,968	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	120,373	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	390,852	0	2.00
3.00	Physical Therapy	0	0	0	0	79,571	0	3.00
4.00	Occupational Therapy	0	0	0	0	37,214	0	4.00
5.00	Speech Pathology	0	0	0	0	4,069	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	35,821	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	667,900	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	120,373						1.00
2.00	Skilled Nursing Care	390,852	85,928	476,780				2.00
3.00	Physical Therapy	79,571	17,494	97,065				3.00
4.00	Occupational Therapy	37,214	8,181	45,395				4.00
5.00	Speech Pathology	4,069	895	4,964				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	35,821	7,875	43,696				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	667,900	120,373	667,900				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.219849					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-2 Part II Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,263	1,263	130,267	0	58,006	1,263	1.00
2.00	Skilled Nursing Care	0	0	178,799	0	330,107	0	2.00
3.00	Physical Therapy	0	0	36,401	0	67,204	0	3.00
4.00	Occupational Therapy	0	0	17,024	0	31,430	0	4.00
5.00	Speech Pathology	0	0	1,862	0	3,437	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	16,387	0	30,254	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,263	1,263	380,740		520,438	1,263	20.00
21.00	Total cost to be allocated	14,173	11,416	94,747		95,769	11,130	21.00
22.00	Unit cost multiplier	11.221694	9.038797	0.248850		0.184016	8.812352	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,263	0	1,263	0	15,309	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,263	0	1,263	0	15,309	0	20.00
21.00	Total cost to be allocated	6,810	0	4,785	0	28,968	0	21.00
22.00	Unit cost multiplier	5.391924	0.000000	3.788599	0.000000	1.892220	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2013 To 08/31/2014

Worksheet H-2 Part II Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I

PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	476,780		476,780	2,083	228.89	1.00
2.00	Physical Therapy	3.00	97,065	0	97,065	1,139	85.22	2.00
3.00	Occupational Therapy	4.00	45,395	0	45,395	492	92.27	3.00
4.00	Speech Pathology	5.00	4,964	0	4,964	34	146.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	43,696		43,696	484	90.28	6.00
7.00	Total (sum of lines 1-6)		667,900	0	667,900	4,232		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	59	1,186			8.00
9.00	Physical Therapy		99914	33	610			9.00
10.00	Occupational Therapy		99914	12	249			10.00
11.00	Speech Pathology		99914	0	17			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	24	343			13.00
14.00	Total (sum of lines 8-13)			128	2,405			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	1,037	1,037	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	59	1,186		13,505	271,464		1.00
2.00	Physical Therapy	33	610		2,812	51,984		2.00
3.00	Occupational Therapy	12	249		1,107	22,975		3.00
4.00	Speech Pathology	0	17		0	2,482		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	24	343		2,167	30,966		6.00
7.00	Total (sum of lines 1-6)	128	2,405		19,591	379,871		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 1/26/2015 1:09 pm

Title XVIII | Home Health Agency I | PPS

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	284,969	1.00
2.00	Physical Therapy	54,796	2.00
3.00	Occupational Therapy	24,082	3.00
4.00	Speech Pathology	2,482	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	33,133	6.00
7.00	Total (sum of lines 1-6)	399,462	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 1/26/2015 1:09 pm

HHA CCN: 147622 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.658765	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.260013	3,989	1,037	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.944662	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140019 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/26/2015 1:09 pm

HHA CCN: 147622 | Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	13,987	281,523	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	18,406	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,025	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,215	2,829	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,858	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	15,202	314,641	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	15,202	314,641	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	15,202	314,641	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	15,202	314,641	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	15,202	314,641	31.00
31.01	Sequestration adjustment (see instructions)	304	6,293	31.01
32.00	Interim payments (see instructions)	14,898	308,348	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2013 To 08/31/2014 | Worksheet H-5 | Date/Time Prepared: 1/26/2015 1:09 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,898		308,348	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		14,898		308,348	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,898		308,348	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140019	Period: From 09/01/2013 To 08/31/2014	Worksheet L Parts I-III Date/Time Prepared: 1/26/2015 1:09 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	95,320	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	4.16	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	95,320	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2013 To 08/31/2014 | Worksheet M-1 | Date/Time Prepared: 1/26/2015 1:09 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	403,447	0	403,447	0	403,447	1.00
2.00	Physician Assistant	87,268	0	87,268	0	87,268	2.00
3.00	Nurse Practitioner	77,425	0	77,425	0	77,425	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	96,959	13,607	110,566	0	110,566	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	665,099	13,607	678,706	0	678,706	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	12,308	12,308	0	12,308	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	1,737	1,737	0	1,737	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	14,045	14,045	0	14,045	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	665,099	27,652	692,751	0	692,751	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	1,233	1,233	0	1,233	29.00
30.00	Administrative Costs	92,409	34,535	126,944	51,617	178,561	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	92,409	35,768	128,177	51,617	179,794	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	757,508	63,420	820,928	51,617	872,545	32.00

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

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2013 To 08/31/2014 | Worksheet M-1 | Date/Time Prepared: 1/26/2015 1:09 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	403,447		1.00
2.00	Physician Assistant	0	87,268		2.00
3.00	Nurse Practitioner	0	77,425		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	110,566		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	678,706		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	12,308		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	1,737		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	14,045		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	692,751		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	1,233		29.00
30.00	Administrative Costs	-1,180	177,381		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,180	178,614		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,180	871,365		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2013 To 08/31/2014 | Worksheet M-2 Date/Time Prepared: 1/26/2015 1:09 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.47	3,257	4,200	6,174		1.00
2.00	Physician Assistant	1.02	1,960	2,100	2,142		2.00
3.00	Nurse Practitioner	0.73	1,403	2,100	1,533		3.00
4.00	Subtotal (sum of lines 1-3)	3.22	6,620		9,849	9,849	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)	3.22	6,620			9,849	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					692,751	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					692,751	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)					178,614	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					705,848	15.00
16.00	Total overhead (sum of lines 14 and 15)					884,462	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					884,462	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					884,462	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,577,213	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2013 To 08/31/2014	Worksheet M-3 Date/Time Prepared: 1/26/2015 1:09 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,577,213	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,713	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,569,500	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,849	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,849	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		159.36	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)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	159.36	159.36	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,361	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	376,249	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) *		376,249	16.00
16.01	Total program charges (see instructions)(from contractor's records)		219,942	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,572	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,400	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.)		284,972	16.04
16.05	Total program cost (see instructions)		289,372	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,634	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,347	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		289,372	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,166	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		294,538	22.00
23.00	Allowable bad debts (see instructions)		13,630	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,994	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,630	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		306,532	26.00
26.01	Sequestration adjustment (see instructions)		6,131	26.01
27.00	Interim payments		319,606	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		-19,205	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: 140019 Component CCN: 143446	Period: From 09/01/2013 To 08/31/2014	Worksheet M-4 Date/Time Prepared: 1/26/2015 1:09 pm
	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)	678,706	678,706	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000093	0.000821	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	63	557	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,253	1,515	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,316	2,072	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	692,751	692,751	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	884,462	884,462	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001900	0.002991	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,680	2,645	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,996	4,717	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	150	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	176.24	31.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	17	69	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,996	2,170	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)		7,713	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)		5,166	16.00

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2013 To 08/31/2014 | Worksheet M-5 | Date/Time Prepared: 1/26/2015 1:09 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		253,878	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		04/22/2014	35,887	3.01
3.02		08/28/2014	29,841	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)		65,728	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		319,606	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		19,205	6.02
7.00	Total Medicare program liability (see instructions)		300,401	7.00

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