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: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 3:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2014 Time: 3:41 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 GENESIS MEDICAL CENTER - ALEDO (141304) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

VICE PRESIDENT, FINANCE/CFO
Title

11/25/2014
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	221,750	-131,718	0	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	77,172	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		-18,231		0	10.00
200.00	Total	0	298,922	-149,949	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 3:40 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	19340		05/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GENESIS MEDICAL CENTER - ALEDO, RHC	143453	19340		02/29/2000	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
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)			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.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 3:40 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.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 3:40 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: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 3:40 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.	Y	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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	7,451	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 3:40 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)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05001	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	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)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 3:40 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)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	11/02/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 3:40 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		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.	MARTY	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 3:40 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	11/02/2014			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR, REIMBURSEMENT		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: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2014 3:40 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	22	8,030	12,936.00	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)		22	8,030	12,936.00	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)		22	8,030	12,936.00	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	116.00	0	0			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)		22				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: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 3:40 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)	421	12	539			1.00
2.00	HMO and other (see instructions)	64	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	838	0	1,038			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,259	12	1,577			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)	1,259	12	1,577	0.00	78.48	14.00
15.00	CAH visits	5,819	2,917	15,228			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,110	4,279	14,983	0.00	19.24	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	97.72	27.00
28.00	Observation Bed Days		32	306			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 3:40 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	135	5	273	1.00
2.00	HMO and other (see instructions)			11	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	135	5	273	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	0.00					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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 | Date/Time Prepared: 11/21/2014 3:40 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1007 NW 3RD STREET	1.00
		City: 1.00	State: 2.00	Zip Code: 3.00
2.00	City, State, Zip Code, County	ALEDO	IL	61231	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award: 1.00	Date: 2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	19:00	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: 1.00	CCN number: 2.00	
14.00	Provider name, CCN number			14.00

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

			County: 4.00				
2.00	City, State, Zip Code, County		MERCER				2.00

		Tuesday	Wednesday		Thursday		
		to: 6.00	from: 7.00	to: 8.00	from: 9.00	to: 10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2013 To 06/30/2014	Worksheet S-8 Date/Time Prepared: 11/21/2014 3:40 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	07:00	19:00	08:00	13:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet S-10 Date/Time Prepared: 11/21/2014 3:40 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)	0.548506	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	704,853	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,674,018	6.00
7.00	Medicaid cost (line 1 times line 6)	1,466,715	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)	761,862	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)	761,862	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	564,905	0	564,905	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	309,854	0	309,854	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)	309,854	0	309,854	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)	606,971	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	123,462	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	483,509	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	265,208	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	575,062	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,336,924	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 3:40 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		20,157	20,157	0	20,157	1.00
1.01	00101	FOUNDATION BLDG		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		34,745	34,745	0	34,745	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,522	734,215	754,737	0	754,737	4.00
5.01	00570	ADMITTING	106,632	12,836	119,468	-2,872	116,596	5.01
5.02	00590	HOSPITAL ONLY A & G	0	150,955	150,955	0	150,955	5.02
5.03	00591	SHARED ADMN & GENERAL	259,373	2,979,187	3,238,560	134,735	3,373,295	5.03
6.00	00600	MAINTENANCE & REPAIRS	229,174	311,922	541,096	0	541,096	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,817	7,765	25,582	0	25,582	8.00
9.00	00900	HOUSEKEEPING	88,066	47,025	135,091	0	135,091	9.00
10.00	01000	DIETARY	52,149	89,641	141,790	0	141,790	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-7,863	-7,863	7,863	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	54,245	5,467	59,712	0	59,712	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	745,679	156,168	901,847	-8,044	893,803	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,226	90,740	155,966	-20,057	135,909	50.00
53.00	05300	ANESTHESIOLOGY	0	216,294	216,294	-354	215,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	443,118	343,061	786,179	-25,747	760,432	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	430,015	531,301	961,316	-3,949	957,367	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,948	3,948	63.00
65.00	06500	RESPIRATORY THERAPY	160,043	38,775	198,818	-18,997	179,821	65.00
66.00	06600	PHYSICAL THERAPY	275,414	75,298	350,712	0	350,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	72,106	72,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,783	1,783	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	216,826	417,166	633,992	-56	633,936	73.00
76.00	03950	SLEEP LAB	13,168	6,135	19,303	-424	18,879	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,309,433	336,466	1,645,899	-133,658	1,512,241	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	646,782	962,680	1,609,462	-4,436	1,605,026	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	157	118	275	-275	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,133,839	7,560,254	12,694,093	1,566	12,695,659	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	235,087	123,914	359,001	-1,566	357,435	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	1,478	1,478	0	1,478	194.04
200.00		TOTAL (SUM OF LINES 118-199)	5,368,926	7,685,646	13,054,572	0	13,054,572	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 3:40 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	0	20,157		1.00
1.01	00101	FOUNDATION BLDG	0	0		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-69,775	-35,030		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-895	753,842		4.00
5.01	00570	ADMITTING	0	116,596		5.01
5.02	00590	HOSPITAL ONLY A & G	-23,362	127,593		5.02
5.03	00591	SHARED ADMN & GENERAL	-914,619	2,458,676		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	541,096		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,582		8.00
9.00	00900	HOUSEKEEPING	0	135,091		9.00
10.00	01000	DIETARY	-33,887	107,903		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	98,199	98,199		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,071	35,071		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,758	143,758		16.00
17.00	01700	SOCIAL SERVICE	-2,500	57,212		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	893,803		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	135,909		50.00
53.00	05300	ANESTHESIOLOGY	13,020	228,960		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-141	760,291		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-1,336	956,031		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,948		63.00
65.00	06500	RESPIRATORY THERAPY	0	179,821		65.00
66.00	06600	PHYSICAL THERAPY	2,530	353,242		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	72,106		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,783		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,966	626,970		73.00
76.00	03950	SLEEP LAB	0	18,879		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-54,081	1,458,160		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-104,788	1,500,238		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-919,772	11,775,887		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-145,345	212,090		192.00
194.00	07950	BOARD OF HEALTH	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0		194.01
194.02	07952	MOBILE MEALS	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	1,478		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,065,117	11,989,455		200.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 3:40 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	127,284	0		1.00
	TOTALS		127,284	0		
	C - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	3,683	265		1.00
	TOTALS		3,683	265		
	D - MALPRACTICE INSURANCE					
1.00	SHARED ADMN & GENERAL	5.03	0	7,451		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	7,451		
	E - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	81,754		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,783		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	83,537		
	F - RECLASS BALANCE NEG BALANCE TO M/S					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,865		1.00
	TOTALS		0	7,865		
	G - MISC AMBLNCE COSTS					
1.00	ADULTS & PEDIATRICS	30.00	157	118		1.00
	TOTALS		157	118		
500.00	Grand Total: Increases		131,124	99,236		500.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 3:40 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RHC SALARY						
1.00	RURAL HEALTH CLINIC	88.00	127,284	0	0		1.00
	TOTALS		127,284	0			
	C - BLOOD						
1.00	LABORATORY	60.00	3,683	265	0		1.00
	TOTALS		3,683	265			
	D - MALPRACTICE INSURANCE						
1.00	RURAL HEALTH CLINIC	88.00	0	6,062	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,389	0		2.00
	TOTALS		0	7,451			
	E - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	RESPIRATORY THERAPY	65.00	0	18,997	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	354	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,747	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	312	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	177	0		5.00
6.00	ADMITTING	5.01	0	2,872	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	8,319	0		7.00
8.00	OPERATING ROOM	50.00	0	20,057	0		8.00
9.00	SLEEP LAB	76.00	0	424	0		9.00
10.00	LABORATORY	60.00	0	1	0		10.00
11.00	EMERGENCY	91.00	0	4,436	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	2	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	56	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,783	0		14.00
	TOTALS		0	83,537			
	F - RECLASS BALANCE NEG BALANCE TO M/S						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,865	0		1.00
	TOTALS		0	7,865			
	G - MISC AMBLNCE COSTS						
1.00	AMBULANCE SERVICES	95.00	157	118	0		1.00
	TOTALS		157	118			
500.00	Grand Total: Decreases		131,124	99,236			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2014 3:40 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	8,829	0	0	0	0	2.00
3.00	Buildings and Fixtures	215,397	0	0	0	0	3.00
4.00	Building Improvements	1,355,849	7,122,667	0	7,122,667	0	4.00
5.00	Fixed Equipment	10,920	296,201	0	296,201	0	5.00
6.00	Movable Equipment	109,793	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,765,788	7,418,868	0	7,418,868	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,765,788	7,418,868	0	7,418,868	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,000	0	1.00
2.00	Land Improvements	8,829	0	2.00
3.00	Buildings and Fixtures	215,397	0	3.00
4.00	Building Improvements	8,478,516	0	4.00
5.00	Fixed Equipment	307,121	0	5.00
6.00	Movable Equipment	109,793	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,184,656	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	9,184,656	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2014 3:40 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	20,157	0	0	0	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	34,745	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	54,902	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	20,157		1.00
1.01	FOUNDATION BLDG	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	34,745		2.00
3.00	Total (sum of lines 1-2)	0	54,902		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2014 3:40 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	215,397	0	215,397	0.662373	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.337627	0	2.00
3.00	Total (sum of lines 1-2)	325,190	0	325,190	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	20,157	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	-35,030	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	-14,873	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	20,157	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	-35,030	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	-14,873	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 3:40 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - FOUNDATION BLDG (chapter 2)		0	FOUNDATION BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,140	EMPLOYEE BENEFITS DEPARTMENT	4.00	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)	A	-1,609	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-152,316			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	-456,389			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,134	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	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
26.01	Depreciation - FOUNDATION BLDG		0	FOUNDATION BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 3:40 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-68,166	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	OTHER REVENUE - VENDOR REBATES	B	-1,608	DIETARY	10.00	0	34.00
35.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-145	DIETARY	10.00	0	35.00
36.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-2,500	SOCIAL SERVICE	17.00	0	36.00
37.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	13,020	ANESTHESIOLOGY	53.00	0	37.00
38.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-141	RADIOLOGY-DIAGNOSTIC	54.00	0	38.00
39.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-1,336	LABORATORY	60.00	0	39.00
40.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	3,784	PHYSICAL THERAPY	66.00	0	40.00
41.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-983	PHYSICAL THERAPY	66.00	0	41.00
42.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-841	DRUGS CHARGED TO PATIENTS	73.00	0	42.00
43.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-6,125	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-5,684	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-172	EMERGENCY	91.00	9	45.00
45.01	OTHER REVENUE - MISCELLANEOUS REVENU	B	-18,029	SHARED ADMN & GENERAL	5.03	0	45.01
45.02	LOBBY DUES	A	-7,999	SHARED ADMN & GENERAL	5.03	0	45.02
45.03	PATIENT PHONES SALARY	A	-912	SHARED ADMN & GENERAL	5.03	0	45.03
45.04	PATIENT PHONES BENEFITS	A	-125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
45.05	PATIENT PHONES COST	A	-2,447	SHARED ADMN & GENERAL	5.03	0	45.05
45.06	ADVERTISING	A	-1,733	SHARED ADMN & GENERAL	5.03	0	45.06
45.07	ADVERTISING	A	-271	PHYSICAL THERAPY	66.00	0	45.07
45.08	ADVERTISING	A	-440	RURAL HEALTH CLINIC	88.00	0	45.08
45.09	ADVERTISING	A	-257	RURAL HEALTH CLINIC	88.00	0	45.09
45.10	ADVERTISING	A	-348	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.10
45.11	OCCUPATIONAL HEALTH	A	-698	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
45.12	PROVIDER TAX ASSESSMENT	A	-172,376	SHARED ADMN & GENERAL	5.03	0	45.12
45.13	PROFESSIONAL FEES OFFSET 100% PART B	A	-144,997	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,065,117				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2014 3:40 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE EQUIP CAPITAL	13,857	0	1.00
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE EQUIP CAPITAL	246,794	0	2.00
3.00	5.03	SHARED ADMN & GENERAL	HOCR POOLED COSTS	803,746	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	1,068	0	4.00
4.01	5.03	SHARED ADMN & GENERAL	LEGAL FEES	134,400	0	4.01
4.02	5.03	SHARED ADMN & GENERAL	DATA PROCESSING	191,841	907,620	4.02
4.03	5.02	HOSPITAL ONLY A & G	PATIENT ACCOUNTING	127,313	150,675	4.03
4.04	5.03	SHARED ADMN & GENERAL	SBS PATIENT ACCESS	142,207	1,612,666	4.04
4.06	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	143,758	0	4.06
4.10	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	35,071	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	MEDICAL AFFAIRS	22,867	0	4.11
4.12	5.03	SHARED ADMN & GENERAL	PAYOR CONTRACTING	11,604	0	4.12
4.13	13.00	NURSING ADMINISTRATION	CARE COORDINATION	98,199	0	4.13
4.14	5.03	SHARED ADMN & GENERAL	HOME OFFICE ADMIN COSTS	7,736	0	4.14
4.15	5.03	SHARED ADMN & GENERAL	LIBRARY	7,164	0	4.15
4.16	5.03	SHARED ADMN & GENERAL	AFFILIATE FACILITIES	226,947	0	4.16
4.18	5.03	SHARED ADMN & GENERAL	VARIOUS SERVICES - RELATED	4,127	4,127	4.18
4.19	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	15,673	15,673	4.19
4.20	9.00	HOUSEKEEPING	VARIOUS SERVICES - RELATED	1,173	1,173	4.20
4.21	10.00	DIETARY	VARIOUS SERVICES - RELATED	33,632	33,632	4.21
4.22	17.00	SOCIAL SERVICE	VARIOUS SERVICES - RELATED	10	10	4.22
4.24	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	14,770	14,770	4.24
4.25	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	1,004	1,004	4.25
4.26	53.00	ANESTHESIOLOGY	VARIOUS SERVICES - RELATED	354	354	4.26
4.27	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	2,067	2,067	4.27
4.28	60.00	LABORATORY	VARIOUS SERVICES - RELATED	2,115	2,115	4.28
4.29	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	19,736	19,736	4.29
4.30	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	3,052	3,052	4.30
4.31	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	36,675	36,675	4.31
4.32	76.00	SLEEP LAB	VARIOUS SERVICES - RELATED	67	67	4.32
4.33	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	1,354	1,354	4.33
4.34	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	4,869	4,869	4.34
4.35	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS SERVICES - RELATED	188	188	4.35
4.36	194.04	RETAIL PHARMACY	VARIOUS SERVICES - RELATED	242	242	4.36
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,355,680	2,812,069	5.00

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

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

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

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

6.00	A	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/21/2014 3:40 pm

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/21/2014 3:40 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	13,857	0		1.00
2.00	246,794	0		2.00
3.00	803,746	0		3.00
4.00	1,068	0		4.00
4.01	134,400	0		4.01
4.02	-715,779	0		4.02
4.03	-23,362	0		4.03
4.04	-1,470,459	0		4.04
4.06	143,758	0		4.06
4.10	35,071	0		4.10
4.11	22,867	0		4.11
4.12	11,604	0		4.12
4.13	98,199	0		4.13
4.14	7,736	0		4.14
4.15	7,164	0		4.15
4.16	226,947	0		4.16
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
4.34	0	0		4.34
4.35	0	0		4.35
4.36	0	0		4.36
5.00	-456,389			5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2014 3:40 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	91.00	AGGREGATE-EMERGENCY	853,825	104,616	749,209	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	878,815	47,700	831,115	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,732,640	152,316	1,580,324		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	104,616		1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	47,700		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	152,316		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 3:40 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					64	1.00
2.00	Line 1 multiplied by 15 hours per week					960	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					251	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,068.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	90.71	72.57	54.43	36.28	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	27.22			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					77,505	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					77,505	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					77,505	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					77,505	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					9,109	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,109	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,381	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,490	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,490	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 3:40 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.57	54.43	36.28	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	77,505		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,490		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	87,995		63.00
64.00	Total cost of outside supplier services (from your records)	42,128		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,109		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,381		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,490		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,381		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,381		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS FOUNDATION BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	20,157	20,157				1.00
1.01	00101	FOUNDATION BLDG	0	0	0			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-35,030			-35,030		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	753,842	64	0	0	753,906	4.00
5.01	00570	ADMITTING	116,596	70	0	0	15,031	5.01
5.02	00590	HOSPITAL ONLY A & G	127,593	225	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	2,458,676	2,507	0	0	54,503	5.03
6.00	00600	MAINTENANCE & REPAIRS	541,096	1,370	0	0	32,304	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,582	418	0	0	2,511	8.00
9.00	00900	HOUSEKEEPING	135,091	162	0	0	12,414	9.00
10.00	01000	DIETARY	107,903	1,286	0	0	7,351	10.00
11.00	01100	CAFETERIA	0	588	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	98,199	95	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,071	1,073	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,758	647	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	57,212	46	0	0	7,646	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	893,803	4,157	0	0	105,132	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	135,909	1,668	0	0	9,194	50.00
53.00	05300	ANESTHESIOLOGY	228,960	59	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,291	1,121	0	0	62,461	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	956,031	643	0	0	60,095	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,948	28	0	0	519	63.00
65.00	06500	RESPIRATORY THERAPY	179,821	159	0	0	22,560	65.00
66.00	06600	PHYSICAL THERAPY	353,242	466	0	0	38,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,106	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,783	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	626,970	255	0	0	30,564	73.00
76.00	03950	SLEEP LAB	18,879	453	0	0	1,856	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,458,160	0	0	0	166,635	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,500,238	1,713	0	0	91,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,775,887	19,273	0	0	720,768	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	177	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	212,090	0	0	0	33,138	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	707	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	1,478	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-35,030	0	201.00
202.00		TOTAL (sum lines 118-201)	11,989,455	20,157	0	-35,030	753,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	ADMITTING	Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	131,697					5.01
5.02	00590	HOSPITAL ONLY A & G	0	127,818	127,818			5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,515,686	27,598	2,543,284	2,543,284	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	574,770	6,306	581,076	155,882	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,511	313	28,824	7,732	8.00
9.00	00900	HOUSEKEEPING	0	147,667	1,620	149,287	40,048	9.00
10.00	01000	DIETARY	0	116,540	1,279	117,819	31,607	10.00
11.00	01100	CAFETERIA	0	588	6	594	159	11.00
13.00	01300	NURSING ADMINISTRATION	0	98,294	1,078	99,372	26,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,144	397	36,541	9,803	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	144,405	1,584	145,989	39,164	16.00
17.00	01700	SOCIAL SERVICE	0	64,904	712	65,616	17,602	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,539	1,014,631	11,132	1,025,763	275,176	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,266	151,037	1,657	152,694	40,962	50.00
53.00	05300	ANESTHESIOLOGY	1,876	230,895	2,533	233,428	62,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,773	854,646	9,376	864,022	231,787	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	30,519	1,047,288	11,490	1,058,778	284,033	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	264	4,759	52	4,811	1,291	63.00
65.00	06500	RESPIRATORY THERAPY	3,340	205,880	2,259	208,139	55,836	65.00
66.00	06600	PHYSICAL THERAPY	6,276	398,806	4,375	403,181	108,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,235	74,341	816	75,157	20,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48	1,831	20	1,851	497	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,876	675,665	7,413	683,078	183,246	73.00
76.00	03950	SLEEP LAB	683	21,871	240	22,111	5,932	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,624,795	17,826	1,642,621	440,658	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	22,002	1,615,123	17,720	1,632,843	438,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,697	11,776,895	127,802	11,776,879	2,477,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	177	0	177	47	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	245,228	0	245,228	65,786	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	707	0	707	0	194.03
194.04	07955	RETAIL PHARMACY	0	1,478	16	1,494	401	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	-35,030	0	-35,030	0	201.00
202.00		TOTAL (sum lines 118-201)	131,697	11,989,455	127,818	11,989,455	2,543,284	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	736,958					6.00
7.00	00700	OPERATION OF PLANT	0	0				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,593	0	53,149			8.00
9.00	00900	HOUSEKEEPING	6,435	0	0	195,770		9.00
10.00	01000	DIETARY	51,026	0	0	16,417	216,869	10.00
11.00	01100	CAFETERIA	23,325	0	0	7,505	97,263	11.00
13.00	01300	NURSING ADMINISTRATION	3,782	0	0	1,217	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,551	0	0	13,691	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,662	0	0	8,256	0	16.00
17.00	01700	SOCIAL SERVICE	1,841	0	0	592	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	164,841	0	26,528	53,034	51,318	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,174	0	2,099	21,291	0	50.00
53.00	05300	ANESTHESIOLOGY	2,336	0	0	752	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,452	0	6,567	14,302	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	25,523	0	0	8,212	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,109	0	0	357	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,297	0	0	2,026	0	65.00
66.00	06600	PHYSICAL THERAPY	18,474	0	7,086	5,944	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	10,098	0	0	3,249	0	73.00
76.00	03950	SLEEP LAB	17,959	0	148	5,778	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105,458	0	1,260	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	67,936	0	9,461	21,858	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	701,872	0	53,149	184,481	148,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,029	0	0	2,262	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	68,288	194.02
194.03	07953	KIDNEY CENTER	28,057	0	0	9,027	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	736,958	0	53,149	195,770	216,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	128,846					11.00
13.00	01300	NURSING ADMINISTRATION	0	131,029				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	102,586			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	219,071		16.00
17.00	01700	SOCIAL SERVICE	1,800	0	0	0	87,451	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,693	74,755	6,163	19,195	87,451	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,691	7,433	3,147	7,097	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,644	0	5,461	51,189	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	18,135	0	66,238	50,767	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	86	0	0	439	0	63.00
65.00	06500	RESPIRATORY THERAPY	5,759	21	617	5,555	0	65.00
66.00	06600	PHYSICAL THERAPY	7,593	3,705	423	10,440	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,960	3,717	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	80	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,662	0	174	29,737	0	73.00
76.00	03950	SLEEP LAB	360	0	214	1,136	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	23,723	0	1,795	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,049	45,115	4,525	36,599	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	125,195	131,029	100,717	219,071	87,451	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	3,651	0	1,869	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	128,846	131,029	102,586	219,071	87,451	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 3:40 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
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,812,917	0	1,812,917		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	303,588	0	303,588		50.00
53.00	05300	ANESTHESIOLOGY	0	302,257	0	302,257		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,231,424	0	1,231,424		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	1,511,686	0	1,511,686		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,093	0	8,093		63.00
65.00	06500	RESPIRATORY THERAPY	0	284,250	0	284,250		65.00
66.00	06600	PHYSICAL THERAPY	0	565,005	0	565,005		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	110,996	0	110,996		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,428	0	2,428		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	914,244	0	914,244		73.00
76.00	03950	SLEEP LAB	0	53,638	0	53,638		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,215,515	0	2,215,515		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	2,274,421	0	2,274,421		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,590,462	0	11,590,462		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,515	0	9,515		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	316,534	0	316,534		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	68,288	0	68,288		194.02
194.03	07953	KIDNEY CENTER	0	37,791	0	37,791		194.03
194.04	07955	RETAIL PHARMACY	0	1,895	0	1,895		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	-35,030	0	-35,030		201.00
202.00		TOTAL (sum lines 118-201)	0	11,989,455	0	11,989,455		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				BLDG & FIXT	FOUNDATION BLDG	MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	64	0	0	64	4.00
5.01	00570	ADMITTING	0	70	0	0	70	5.01
5.02	00590	HOSPITAL ONLY A & G	0	225	0	0	225	5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,507	0	0	2,507	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	1,370	0	0	1,370	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	418	0	0	418	8.00
9.00	00900	HOUSEKEEPING	0	162	0	0	162	9.00
10.00	01000	DIETARY	0	1,286	0	0	1,286	10.00
11.00	01100	CAFETERIA	0	588	0	0	588	11.00
13.00	01300	NURSING ADMINISTRATION	0	95	0	0	95	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,073	0	0	1,073	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	647	0	0	647	16.00
17.00	01700	SOCIAL SERVICE	0	46	0	0	46	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,157	0	0	4,157	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,668	0	0	1,668	50.00
53.00	05300	ANESTHESIOLOGY	0	59	0	0	59	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,121	0	0	1,121	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	643	0	0	643	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	28	0	0	28	63.00
65.00	06500	RESPIRATORY THERAPY	0	159	0	0	159	65.00
66.00	06600	PHYSICAL THERAPY	0	466	0	0	466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	255	0	0	255	73.00
76.00	03950	SLEEP LAB	0	453	0	0	453	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,713	0	0	1,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	19,273	0	0	19,273	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	177	0	0	177	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	707	0	0	707	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	-35,030	-35,030	201.00
202.00		TOTAL (sum lines 118-201)	0	20,157	0	-35,030	-14,873	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5.02	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	64					4.00
5.01	00570	ADMITTING	1	71				5.01
5.02	00590	HOSPITAL ONLY A & G	0	0	225			5.02
5.03	00591	SHARED ADMN & GENERAL	5	0	51	2,563		5.03
6.00	00600	MAINTENANCE & REPAIRS	3	0	11	157	1,541	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1	8	35	8.00
9.00	00900	HOUSEKEEPING	1	0	3	40	13	9.00
10.00	01000	DIETARY	1	0	2	32	107	10.00
11.00	01100	CAFETERIA	0	0	0	0	49	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2	27	8	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1	10	89	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3	39	54	16.00
17.00	01700	SOCIAL SERVICE	1	0	1	18	4	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9	6	19	277	343	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1	2	3	41	138	50.00
53.00	05300	ANESTHESIOLOGY	0	1	4	63	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5	17	16	233	93	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5	17	20	286	53	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1	2	63.00
65.00	06500	RESPIRATORY THERAPY	2	2	4	56	13	65.00
66.00	06600	PHYSICAL THERAPY	3	3	8	109	39	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	1	20	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	3	10	13	184	21	73.00
76.00	03950	SLEEP LAB	0	0	0	6	38	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13	0	31	449	221	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8	12	31	441	142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61	71	225	2,497	1,467	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	0	0	66	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	59	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	64	71	225	2,563	1,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	462				8.00
9.00	00900	HOUSEKEEPING	0	0	219			9.00
10.00	01000	DIETARY	0	0	18	1,446		10.00
11.00	01100	CAFETERIA	0	0	8	649	1,294	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	15	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	9	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1	0	18	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	231	61	342	288	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18	24	0	27	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57	16	0	137	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	9	0	182	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	2	0	58	65.00
66.00	06600	PHYSICAL THERAPY	0	62	7	0	76	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	4	0	47	73.00
76.00	03950	SLEEP LAB	0	1	6	0	4	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11	0	0	238	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	82	24	0	181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	462	206	991	1,257	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	37	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	455	0	194.02
194.03	07953	KIDNEY CENTER	0	0	10	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	0	462	219	1,446	1,294	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	133					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,188				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	752			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	89		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75	71	66	89		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8	36	24	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	11	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63	178	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	768	173	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	7	19	0		65.00
66.00	06600	PHYSICAL THERAPY	4	5	36	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	139	13	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2	102	0		73.00
76.00	03950	SLEEP LAB	0	2	4	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	21	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	46	52	125	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	133	1,166	752	89	0	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	22	0	0		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	0	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0		194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	133	1,188	752	89	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	FOUNDATION BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
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
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,034	0	6,034		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,990	0	1,990		50.00
53.00	05300	ANESTHESIOLOGY	144	0	144		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,936	0	1,936		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	2,156	0	2,156		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	33	0	33		63.00
65.00	06500	RESPIRATORY THERAPY	322	0	322		65.00
66.00	06600	PHYSICAL THERAPY	818	0	818		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	174	0	174		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641	0	641		73.00
76.00	03950	SLEEP LAB	514	0	514		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	984	0	984		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,857	0	2,857		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,603	0	18,603		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195	0	195		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	128	0	128		192.00
194.00	07950	BOARD OF HEALTH	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0		194.01
194.02	07952	MOBILE MEALS	455	0	455		194.02
194.03	07953	KIDNEY CENTER	776	0	776		194.03
194.04	07955	RETAIL PHARMACY	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	-35,030	0	-35,030		201.00
202.00		TOTAL (sum lines 118-201)	-14,873	0	-14,873		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHAR GES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	40,379					1.00
1.01	00101	FOUNDATION BLDG	0	0				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			107,090			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	129	0	0	5,348,404		4.00
5.01	00570	ADMITTING	140	0	0	106,632	17,820,244	5.01
5.02	00590	HOSPITAL ONLY A & G	450	0	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	5,023	0	15,029	386,657	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	2,744	0	2,756	229,174	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	838	0	0	17,817	0	8.00
9.00	00900	HOUSEKEEPING	325	0	0	88,066	0	9.00
10.00	01000	DIETARY	2,577	0	0	52,149	0	10.00
11.00	01100	CAFETERIA	1,178	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	191	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,149	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,296	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	93	0	0	54,245	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,325	0	20,419	745,836	1,561,478	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,342	0	2,710	65,226	577,295	50.00
53.00	05300	ANESTHESIOLOGY	118	0	0	0	253,830	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245	0	42,991	443,118	4,163,557	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,289	0	15,456	426,332	4,129,778	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56	0	0	3,683	35,678	63.00
65.00	06500	RESPIRATORY THERAPY	318	0	1,804	160,043	451,899	65.00
66.00	06600	PHYSICAL THERAPY	933	0	890	275,414	849,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	302,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510	0	0	216,826	2,418,988	73.00
76.00	03950	SLEEP LAB	907	0	3,631	13,168	92,439	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	494	1,182,149	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,431	0	910	646,782	2,977,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,607	0	107,090	5,113,317	17,820,244	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	235,087	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	1,417	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	20,157	0	-35,030	753,906	131,697	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.499195	0.000000	0.000000	0.140959	0.007390	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				64	71	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000012	0.000004	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	Reconciliation	HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	-127,818	11,650,555				5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,515,686	-2,543,284	9,480,494		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	574,770	0	581,076	37,219	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,511	0	28,824	838	8.00
9.00	00900	HOUSEKEEPING	0	147,667	0	149,287	325	9.00
10.00	01000	DIETARY	0	116,540	0	117,819	2,577	10.00
11.00	01100	CAFETERIA	0	588	0	594	1,178	11.00
13.00	01300	NURSING ADMINISTRATION	0	98,294	0	99,372	191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,144	0	36,541	2,149	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	144,405	0	145,989	1,296	16.00
17.00	01700	SOCIAL SERVICE	0	64,904	0	65,616	93	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,014,631	0	1,025,763	8,325	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	151,037	0	152,694	3,342	50.00
53.00	05300	ANESTHESIOLOGY	0	230,895	0	233,428	118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	854,646	0	864,022	2,245	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,047,288	0	1,058,778	1,289	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,759	0	4,811	56	63.00
65.00	06500	RESPIRATORY THERAPY	0	205,880	0	208,139	318	65.00
66.00	06600	PHYSICAL THERAPY	0	398,806	0	403,181	933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	74,341	0	75,157	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,831	0	1,851	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	675,665	0	683,078	510	73.00
76.00	03950	SLEEP LAB	0	21,871	0	22,111	907	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,624,795	0	1,642,621	5,326	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,615,123	0	1,632,843	3,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-127,818	11,649,077	-2,543,284	9,233,595	35,447	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-177	0	0	177	355	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-245,228	0	0	245,228	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	-707	0	-707	0	1,417	194.03
194.04	07955	RETAIL PHARMACY	0	1,478	0	1,494	0	194.04
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)		127,818		2,543,284	736,958	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.010971		0.268265	19.800586	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		225		2,563	1,541	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000019		0.000270	0.041404	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,621				8.00
9.00	00900	HOUSEKEEPING	0	0	30,730			9.00
10.00	01000	DIETARY	0	0	2,577	25,546		10.00
11.00	01100	CAFETERIA	0	0	1,178	11,457	7,517	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	191	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,149	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,296	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	93	0	105	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	27,263	8,325	6,045	1,674	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,157	3,342	0	157	50.00
53.00	05300	ANESTHESIOLOGY	0	0	118	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,749	2,245	0	796	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,289	0	1,058	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	56	0	5	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	318	0	336	65.00
66.00	06600	PHYSICAL THERAPY	0	7,282	933	0	443	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	510	0	272	73.00
76.00	03950	SLEEP LAB	0	152	907	0	21	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,295	0	0	1,384	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	9,723	3,431	0	1,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	54,621	28,958	17,502	7,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	355	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	213	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	8,044	0	194.02
194.03	07953	KIDNEY CENTER	0	0	1,417	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	53,149	195,770	216,869	128,846	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.973051	6.370648	8.489353	17.140615	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	462	219	1,446	1,294	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.008458	0.007127	0.056604	0.172143	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 3:40 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	57,006					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	526,391				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	17,820,244			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	273		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,523	31,622	1,561,478	273		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,234	16,147	577,295	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	253,830	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,021	4,163,557	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	339,891	4,129,778	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	35,678	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9	3,168	451,899	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,612	2,170	849,237	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,368	302,372	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,491	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	891	2,418,988	0	0	73.00
76.00	03950	SLEEP LAB	0	1,099	92,439	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,209	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,628	23,217	2,977,202	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,006	516,803	17,820,244	273	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,588	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
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)	131,029	102,586	219,071	87,451	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.298512	0.194886	0.012293	320.333333	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	133	1,188	752	89	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002333	0.002257	0.000042	0.326007	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,812,917		1,812,917	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	303,588		303,588	0	0	50.00
53.00	05300	ANESTHESIOLOGY	302,257		302,257	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,424		1,231,424	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,511,686		1,511,686	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,093		8,093	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	284,250	0	284,250	0	0	65.00
66.00	06600	PHYSICAL THERAPY	565,005	0	565,005	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,996		110,996	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,428		2,428	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	914,244		914,244	0	0	73.00
76.00	03950	SLEEP LAB	53,638		53,638	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,215,515		2,215,515	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,274,421		2,274,421	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	294,611		294,611		0	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	11,885,073	0	11,885,073	0	0	200.00
201.00		Less Observation Beds	294,611		294,611		0	201.00
202.00		Total (see instructions)	11,590,462	0	11,590,462	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,284,475		1,284,475			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,883	572,412	577,295	0.525880	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,315	251,515	253,830	1.190785	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,815	4,026,742	4,163,557	0.295762	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	302,921	3,826,857	4,129,778	0.366045	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	19,881	15,797	35,678	0.226834	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	186,334	265,565	451,899	0.629012	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	309,047	540,190	849,237	0.665309	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,110	117,262	302,372	0.367084	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,491	6,491	0.374056	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,636	1,112,352	2,418,988	0.377945	0.000000	73.00
76.00	03950	SLEEP LAB	0	92,439	92,439	0.580253	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,310,738	3,310,738			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	35,468	2,941,734	2,977,202	0.763946	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,179	272,824	277,003	1.063566	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	3,778,064	17,352,918	21,130,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,778,064	17,352,918	21,130,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	SLEEP LAB	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	INFUSION CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS		117.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,812,917		1,812,917	0	1,812,917	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	303,588		303,588	0	303,588	50.00
53.00	05300	ANESTHESIOLOGY	302,257		302,257	0	302,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,424		1,231,424	0	1,231,424	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,511,686		1,511,686	0	1,511,686	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,093		8,093	0	8,093	63.00
65.00	06500	RESPIRATORY THERAPY	284,250	0	284,250	0	284,250	65.00
66.00	06600	PHYSICAL THERAPY	565,005	0	565,005	0	565,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,996		110,996	0	110,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,428		2,428	0	2,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	914,244		914,244	0	914,244	73.00
76.00	03950	SLEEP LAB	53,638		53,638	0	53,638	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,215,515		2,215,515	0	2,215,515	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,274,421		2,274,421	0	2,274,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	294,611		294,611		294,611	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	11,885,073	0	11,885,073	0	11,885,073	200.00
201.00		Less Observation Beds	294,611		294,611		294,611	201.00
202.00		Total (see instructions)	11,590,462	0	11,590,462	0	11,590,462	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,284,475		1,284,475			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,883	572,412	577,295	0.525880	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,315	251,515	253,830	1.190785	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,815	4,026,742	4,163,557	0.295762	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	302,921	3,826,857	4,129,778	0.366045	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	19,881	15,797	35,678	0.226834	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	186,334	265,565	451,899	0.629012	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	309,047	540,190	849,237	0.665309	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	185,110	117,262	302,372	0.367084	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,491	6,491	0.374056	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,306,636	1,112,352	2,418,988	0.377945	0.000000	73.00
76.00	03950	SLEEP LAB	0	92,439	92,439	0.580253	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,310,738	3,310,738	0.669191	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	35,468	2,941,734	2,977,202	0.763946	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,179	272,824	277,003	1.063566	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	3,778,064	17,352,918	21,130,982			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,778,064	17,352,918	21,130,982			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	INFUSION CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,990	577,295	0.003447	3,276	11	50.00
53.00	05300	ANESTHESIOLOGY	144	253,830	0.000567	1,256	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,936	4,163,557	0.000465	67,181	31	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	2,156	4,129,778	0.000522	129,218	67	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	33	35,678	0.000925	3,210	3	63.00
65.00	06500	RESPIRATORY THERAPY	322	451,899	0.000713	96,912	69	65.00
66.00	06600	PHYSICAL THERAPY	818	849,237	0.000963	20,939	20	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	174	302,372	0.000575	95,273	55	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,491	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	641	2,418,988	0.000265	591,844	157	73.00
76.00	03950	SLEEP LAB	514	92,439	0.005560	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	984	3,310,738	0.000297	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	2,857	2,977,202	0.000960	9,325	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,185	277,003	0.007888	4,179	33	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	14,754	19,846,507		1,022,613	456	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	577,295	0.000000	0.000000	3,276	50.00
53.00	05300	ANESTHESIOLOGY	0	253,830	0.000000	0.000000	1,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,163,557	0.000000	0.000000	67,181	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	4,129,778	0.000000	0.000000	129,218	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	35,678	0.000000	0.000000	3,210	63.00
65.00	06500	RESPIRATORY THERAPY	0	451,899	0.000000	0.000000	96,912	65.00
66.00	06600	PHYSICAL THERAPY	0	849,237	0.000000	0.000000	20,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	302,372	0.000000	0.000000	95,273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,491	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,418,988	0.000000	0.000000	591,844	73.00
76.00	03950	SLEEP LAB	0	92,439	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,310,738	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,977,202	0.000000	0.000000	9,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	277,003	0.000000	0.000000	4,179	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	19,846,507			1,022,613	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.525880	0	182,568	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.190785	0	81,734	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.295762	0	1,347,634	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.366045	0	1,629,468	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.226834	0	9,517	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.629012	0	133,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.665309	0	237,046	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367084	0	59,346	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.374056	0	182	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377945	0	431,298	0	0	73.00
76.00	03950	SLEEP LAB	0.580253	0	32,388	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.763946	0	888,431	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.063566	0	162,057	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	5,194,731	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	5,194,731	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	96,009	0		50.00
53.00	05300	ANESTHESIOLOGY	97,328	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	398,579	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	596,459	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,159	0		63.00
65.00	06500	RESPIRATORY THERAPY	83,698	0		65.00
66.00	06600	PHYSICAL THERAPY	157,709	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,785	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,007	0		73.00
76.00	03950	SLEEP LAB	18,793	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	678,713	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	172,358	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,486,665	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,486,665	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.525880	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.190785	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.295762	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.366045	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.226834	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.629012	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.665309	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367084	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.374056	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377945	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.580253	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.763946	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.063566	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,883	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	845	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)	539	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	404	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)	634	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	421	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)	326	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)	512	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	137.31	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,812,917	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)	999,366	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	813,551	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)	813,551	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	962.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	405,330	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)	405,330	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	416,233	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	821,563	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	313,866	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	492,943	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	806,809	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)	306	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	962.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	294,611	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,034	813,551	0.007417	294,611	2,185	90.00
91.00	Nursing School cost	0	813,551	0.000000	294,611	0	91.00
92.00	Allied health cost	0	813,551	0.000000	294,611	0	92.00
93.00	All other Medical Education	0	813,551	0.000000	294,611	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		376,022		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.525880	3,276	1,723	50.00
53.00	05300	ANESTHESIOLOGY	1.190785	1,256	1,496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.295762	67,181	19,870	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.366045	129,218	47,300	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.226834	3,210	728	63.00
65.00	06500	RESPIRATORY THERAPY	0.629012	96,912	60,959	65.00
66.00	06600	PHYSICAL THERAPY	0.665309	20,939	13,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367084	95,273	34,973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.374056	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377945	591,844	223,684	73.00
76.00	03950	SLEEP LAB	0.580253	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.763946	9,325	7,124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.063566	4,179	4,445	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,022,613	416,233	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,022,613		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3

Component CCN: 14Z304 | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.525880	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.190785	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.295762	20,508	6,065	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.366045	93,628	34,272	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.226834	1,885	428	63.00
65.00	06500	RESPIRATORY THERAPY	0.629012	52,608	33,091	65.00
66.00	06600	PHYSICAL THERAPY	0.665309	226,838	150,917	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367084	79,510	29,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.374056	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377945	394,739	149,190	73.00
76.00	03950	SLEEP LAB	0.580253	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.763946	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.063566	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		869,716	403,150	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)		869,716		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/21/2014 3:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,486,665	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,486,665	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,511,532	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	15,070	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	706,047	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)	1,790,415	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)	1,790,415	30.00
31.00	Primary payer payments	713	31.00
32.00	Subtotal (line 30 minus line 31)	1,789,702	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)	122,177	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	107,516	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	118,988	36.00
37.00	Subtotal (see instructions)	1,897,218	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER	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)	1,897,218	40.00
40.01	Sequestration adjustment (see instructions)	37,944	40.01
41.00	Interim payments	1,990,992	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-131,718	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: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		704,268		1,976,852	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	02/24/2014	14,140	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	02/24/2014	204,960		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)		-204,960		14,140	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)		499,308		1,990,992	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		221,750		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		131,718	6.02
7.00	Total Medicare program liability (see instructions)		721,058		1,859,274	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: 141304 | Component CCN: 14Z304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 3:40 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,282,073		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	02/24/2014	186,539		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)		-186,539		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,095,534		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		77,172		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,172,706		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 - SWING BEDS	Provider CCN: 141304 Component CCN: 14Z304	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/21/2014 3:40 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	814,877	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)	407,182	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	838	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,222,059	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,222,059	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,222,059	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,420	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,196,639	0	15.00
16.00	OTHER	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)	1,196,639	0	19.00
19.01	Sequestration adjustment (see instructions)	23,933	0	19.01
20.00	Interim payments	1,095,534	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	77,172	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/21/2014 3:40 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	821,563	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	821,563	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	829,779	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	829,779	19.00
20.00	Deductibles (exclude professional component)	109,952	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	719,827	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	719,827	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,120	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,946	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,120	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	735,773	28.00
29.00	OTHER	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	735,773	30.00
30.01	Sequestration adjustment (see instructions)	14,715	30.01
31.00	Interim payments	499,308	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	221,750	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/21/2014 3:40 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	1,153,531	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	3,062,049	0	0	0	4.00
5.00	Other receivable	116,121	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,183,962	0	0	0	6.00
7.00	Inventory	281,277	0	0	0	7.00
8.00	Prepaid expenses	63,169	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,492,185	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	8,829	0	0	0	13.00
14.00	Accumulated depreciation	-2,649	0	0	0	14.00
15.00	Buildings	8,693,914	0	0	0	15.00
16.00	Accumulated depreciation	-27,586	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	307,120	0	0	0	19.00
20.00	Accumulated depreciation	-12,786	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	109,793	0	0	0	23.00
24.00	Accumulated depreciation	-32,938	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)	9,108,697	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,600,882	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	504,234	0	0	0	37.00
38.00	Salaries, wages, and fees payable	500,411	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	437,947	0	0	0	40.00
41.00	Deferred income	150,494	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	2,750,084	0	0	0	43.00
44.00	Other current liabilities	124,932	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,468,102	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,012,053	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	5,012,053	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,480,155	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	3,120,727				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)	3,120,727	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,600,882	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/21/2014 3:40 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		2,604,717		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		516,010				2.00
3.00	Total (sum of line 1 and line 2)		3,120,727		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,120,727		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)		3,120,727		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2014 3:40 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	577,081		577,081	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	710,954		710,954	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)	1,288,035		1,288,035	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)	1,288,035		1,288,035	17.00
18.00	Ancillary services	2,478,437	11,179,618	13,658,055	18.00
19.00	Outpatient services	39,647	3,214,558	3,254,205	19.00
20.00	RURAL HEALTH CLINIC	0	3,310,738	3,310,738	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	17,026	2,019,869	2,036,895	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,823,145	19,724,783	23,547,928	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,054,572		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)		13,054,572		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141304	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/21/2014 3:40 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	23,547,928	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,335,033	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,212,895	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,054,572	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-841,677	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	828,470	6.00
7.00	Income from investments	7,485	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	277	10.00
11.00	Rebates and refunds of expenses	1,608	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	32,134	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	444,155	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,378	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY REVENUE	841	24.00
24.01	OTHER REVENUE	24,449	24.01
24.02	RENTAL INCOME	16,862	24.02
25.00	Total other income (sum of lines 6-24)	1,357,659	25.00
26.00	Total (line 5 plus line 25)	515,982	26.00
27.00	RECONCILING ITEM	-28	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-28	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	516,010	29.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 3:40 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	485,291	32,869	518,160	0	518,160	1.00
2.00	Physician Assistant	161,079	10,910	171,989	0	171,989	2.00
3.00	Nurse Practitioner	84,907	5,751	90,658	0	90,658	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	387,300	26,232	413,532	0	413,532	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	57,491	3,894	61,385	-192	61,193	9.00
10.00	Subtotal (sum of lines 1-9)	1,176,068	79,656	1,255,724	-192	1,255,532	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	13,350	13,350	0	13,350	13.00
14.00	Subtotal (sum of lines 11-13)	0	13,350	13,350	0	13,350	14.00
15.00	Medical Supplies	0	9,522	9,522	0	9,522	15.00
16.00	Transportation (Health Care Staff)	0	2,855	2,855	0	2,855	16.00
17.00	Depreciation-Medical Equipment	0	4,180	4,180	0	4,180	17.00
18.00	Professional Liability Insurance	0	7,280	7,280	-6,062	1,218	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	23,837	23,837	-6,062	17,775	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,176,068	116,843	1,292,911	-6,254	1,286,657	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	2,514	2,514	0	2,514	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	2,514	2,514	0	2,514	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	76,174	76,174	0	76,174	29.00
30.00	Administrative Costs	133,366	140,934	274,300	-128,284	146,016	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	133,366	217,108	350,474	-128,284	222,190	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,309,434	336,465	1,645,899	-134,538	1,511,361	32.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 3:40 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	-47,700	470,460		1.00
2.00	Physician Assistant	0	171,989		2.00
3.00	Nurse Practitioner	0	90,658		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	413,532		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	61,193		9.00
10.00	Subtotal (sum of lines 1-9)	-47,700	1,207,832		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	13,350		13.00
14.00	Subtotal (sum of lines 11-13)	0	13,350		14.00
15.00	Medical Supplies	0	9,522		15.00
16.00	Transportation (Health Care Staff)	0	2,855		16.00
17.00	Depreciation-Medical Equipment	0	4,180		17.00
18.00	Professional Liability Insurance	0	1,218		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	17,775		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-47,700	1,238,957		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	2,514		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	2,514		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	76,174		29.00
30.00	Administrative Costs	-5,501	140,515		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,501	216,689		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,201	1,458,160		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141304 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2

Component CCN: 143453 | Date/Time Prepared: 11/21/2014 3:40 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	2.11	7,858	4,200	8,862		1.00
2.00	Physician Assistant	0.72	3,712	2,100	1,512		2.00
3.00	Nurse Practitioner	0.76	3,413	2,100	1,596		3.00
4.00	Subtotal (sum of lines 1-3)	3.59	14,983		11,970	14,983	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)	3.59	14,983			14,983	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,238,957	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					2,514	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,241,471	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.997975	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					216,689	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					757,355	15.00
16.00	Total overhead (sum of lines 14 and 15)					974,044	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					974,044	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					972,072	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,211,029	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/21/2014 3:40 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)		2,211,029	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		408	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,210,621	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		14,983	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)		14,983	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		147.54	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)	147.54	147.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,110	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	458,849	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) *		458,849	16.00
16.01	Total program charges (see instructions)(from contractor's records)		595,035	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		333,338	16.04
16.05	Total program cost (see instructions)		333,338	16.05
17.00	Primary payer amounts		1,403	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,177	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		109,991	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		331,935	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		51	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		331,986	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	SEQUESTRATION RECONCILIATION TO PS&R		0	25.00
26.00	Net reimbursable amount (see instructions)		331,986	26.00
26.01	Sequestration adjustment (see instructions)		6,640	26.01
27.00	Interim payments		343,577	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		-18,231	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: 141304 Component CCN: 143453	Period: From 07/01/2013 To 06/30/2014	Worksheet M-4 Date/Time Prepared: 11/21/2014 3:40 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)	1,207,832	1,207,832	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000094	0.000094	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	114	114	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	114	114	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,238,957	1,238,957	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	974,044	974,044	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000092	0.000092	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	90	90	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	204	204	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	8	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	25.50	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	51	0	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)		408	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)		51	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 11/21/2014 3:40 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		376,291	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		02/24/2014	32,714	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)		-32,714	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		343,577	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		18,231	6.02
7.00	Total Medicare program liability (see instructions)		325,346	7.00

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