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: 141305	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/24/2014 12:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/24/2014 Time: 12:27 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 MEMORIAL HOSPITAL ASSOCIATION (141305) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title 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	-117,900	80,981	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	-15,850	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		5,001		0	10.00
200.00	Total	0	-133,750	85,982	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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2014 8:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 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.	2	N	23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 8:22 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/19/2014 8:22 am

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

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

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

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

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		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	257,950	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
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	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)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/19/2014 8:22 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/01/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/05/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 8:22 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 8:22 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/05/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CHIEF FINANCIAL OFFICER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/19/2014 8:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	33,792.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		18	6,570	33,792.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	33,792.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		18				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2014 8:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	743	288	1,334			1.00
2.00	HMO and other (see instructions)	77	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	680	0	746			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	25			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,423	288	2,105			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		179	283			13.00
14.00	Total (see instructions)	1,423	467	2,388	0.00	145.80	14.00
15.00	CAH visits	6,715	4,059	17,398			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	1,127	0	9,878	0.00	11.40	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	157.20	27.00
28.00	Observation Bed Days		0	325			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	74			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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/19/2014 8:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	233	122	495	1.00
2.00	HMO and other (see instructions)			22	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	233	122	495	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
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: 141305 Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 | Date/Time Prepared: 11/19/2014 8:22 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street		1.00
		City: 1.00	State: 2.00	Zip Code: 3.00
2.00	City, State, Zip Code, County		IL		2.00
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award: 1.00	Date: 2.00
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
9.01			0		9.01
9.02			0		9.02
9.03			0		9.03
9.04			0		9.04
9.05			0		9.05
9.06			0		9.06
9.07			0		9.07
9.08			0		9.08
9.09			0		9.09
9.10			0		9.10
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	2	13.00

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

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

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 | Date/Time Prepared: 11/19/2014 8:22 am

Rural Health Clinic (RHC) I | Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		HANCOCK				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/19/2014 8:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.554004	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,977,376	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,593,565	5.00
6.00	Medicaid charges	9,555,754	6.00
7.00	Medicaid cost (line 1 times line 6)	5,293,926	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,722,985	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	178,055	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,722,985	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	595,105	187,753	782,858	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	329,691	104,016	433,707	21.00
22.00	Partial payment by patients approved for charity care	12,001	20,389	32,390	22.00
23.00	Cost of charity care (line 21 minus line 22)	317,690	83,627	401,317	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)	499,961	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	226,990	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	272,971	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	151,227	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	552,544	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,275,529	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,192,544	1,192,544	-1,166,195	26,349	1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG		107,859	107,859	-14,284	93,575	1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	2,254,750	2,254,750	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		726,862	726,862	25,634	752,496	2.00
2.01	00201	NEW CAP REL COSTS-NH ME		0	0	7,905	7,905	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,717,339	1,717,339	-62,987	1,654,352	4.00
4.01	00401	SHARED HUMAN RESOURCES	78,141	27,340	105,481	0	105,481	4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	443,467	1,550,113	1,993,580	19,389	2,012,969	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	997,034	293,501	1,290,535	0	1,290,535	5.02
7.00	00700	OPERATION OF PLANT	143,707	543,900	687,607	0	687,607	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	9,640	149,138	158,778	0	158,778	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,550	49,550	0	49,550	8.00
9.00	00900	HOUSEKEEPING	100,323	37,332	137,655	0	137,655	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	19,825	1,899	21,724	0	21,724	9.01
10.00	01000	DIETARY	143,398	92,172	235,570	-94,668	140,902	10.00
11.00	01100	CAFETERIA	0	0	0	94,668	94,668	11.00
13.00	01300	NURSING ADMINISTRATION	122,382	65,594	187,976	-37,945	150,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,030	83,176	219,206	10,555	229,761	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	37,945	37,945	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	389,852	21,093	410,945	0	410,945	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,027,602	16,589	1,044,191	176,083	1,220,274	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	178,036	178,036	43.00
46.00	04600	OTHER LONG TERM CARE	0	32,733	32,733	0	32,733	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	277,752	93,581	371,333	0	371,333	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357,298	44,322	401,620	-354,119	47,501	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,539	588,690	1,008,229	0	1,008,229	54.00
56.00	05600	RADIOISOTOPE	0	90,794	90,794	0	90,794	56.00
60.00	06000	LABORATORY	442,861	469,660	912,521	0	912,521	60.00
60.02	06002	GEO PSYCH	81,423	182,572	263,995	0	263,995	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,748	50,748	0	50,748	62.00
65.00	06500	RESPIRATORY THERAPY	176,801	55,022	231,823	-7,914	223,909	65.00
66.00	06600	PHYSICAL THERAPY	0	86,923	86,923	0	86,923	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7,805	7,805	7,914	15,719	69.00
69.01	06901	PULMONARY REHAB	38,544	131,990	170,534	0	170,534	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,898	751,400	786,298	-42,455	743,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	42,455	42,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,348	516,608	658,956	0	658,956	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	837,201	452,606	1,289,807	-93,009	1,196,798	88.00
90.00	09000	CLINIC	1,704,396	369,089	2,073,485	52,432	2,125,917	90.00
91.00	09100	EMERGENCY	321,982	1,773,616	2,095,598	0	2,095,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	57,357	3,560	60,917	0	60,917	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,136,138	1,136,138	-1,136,138	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,503,801	13,513,858	22,017,659	-101,948	21,915,711	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	218,557	48,655	267,212	95,569	362,781	192.00
194.00	07950	NAUVOO APARTMENTS	0	15,101	15,101	6,379	21,480	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	8,722,358	13,577,614	22,299,972	0	22,299,972	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	26,349		1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	0	93,575		1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-21,784	2,232,966		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-203,132	549,364		2.00
2.01	00201	NEW CAP REL COSTS-NH ME	0	7,905		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-74,054	1,580,298		4.00
4.01	00401	SHARED HUMAN RESOURCES	0	105,481		4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	-725,430	1,287,539		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-639	1,289,896		5.02
7.00	00700	OPERATION OF PLANT	-102,266	585,341		7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	158,778		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,550		8.00
9.00	00900	HOUSEKEEPING	0	137,655		9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	21,724		9.01
10.00	01000	DIETARY	-7,096	133,806		10.00
11.00	01100	CAFETERIA	-30,910	63,758		11.00
13.00	01300	NURSING ADMINISTRATION	0	150,031		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,032	226,729		16.00
17.00	01700	SOCIAL SERVICE	0	37,945		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	410,945		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,220,274		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	178,036		43.00
46.00	04600	OTHER LONG TERM CARE	-3,600	29,133		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	371,333		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,501		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-565	1,007,664		54.00
56.00	05600	RADIOISOTOPE	0	90,794		56.00
60.00	06000	LABORATORY	-1,425	911,096		60.00
60.02	06002	GEO PSYCH	-26,535	237,460		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,748		62.00
65.00	06500	RESPIRATORY THERAPY	-90	223,819		65.00
66.00	06600	PHYSICAL THERAPY	0	86,923		66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,719		69.00
69.01	06901	PULMONARY REHAB	0	170,534		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,668	738,175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	42,455		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	658,956		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-45,197	1,151,601		88.00
90.00	09000	CLINIC	-1,585,634	540,283		90.00
91.00	09100	EMERGENCY	-291,616	1,803,982		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	60,917		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,128,673	18,787,038		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	362,781		192.00
194.00	07950	NAUVOO APARTMENTS	0	21,480		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-3,128,673	19,171,299		200.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/19/2014 8:22 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-NH ME	2.01	0	7,905		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,163,635		2.00
3.00	NAUVOO APARTMENTS	194.00	0	6,379		3.00
	TOTALS		0	1,177,919		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	57,639	37,029		1.00
	TOTALS		57,639	37,029		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	2,560		1.00
	TOTALS		0	2,560		
	D - TO RECLASS SOCIAL SERVICES SALARY					
1.00	SOCIAL SERVICE	17.00	37,945	0		1.00
	TOTALS		37,945	0		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	25,634		1.00
2.00	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	19,389		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,091,115		3.00
	TOTALS		0	1,136,138		
	F - TO RECLASS ACUTE AND NURSERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	156,889	19,194		1.00
2.00	NURSERY	43.00	158,629	19,407		2.00
	TOTALS		315,518	38,601		
	G - TO RECLASS BILLING AND TRANSCRIPTION					
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	10,555		1.00
	TOTALS		0	10,555		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	11,988	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	4,074		2.00
	TOTALS		11,988	4,074		
	I - TO RECLASS RHC TIME STUDY					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	95,569	0		1.00
	TOTALS		95,569	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	CLINIC	90.00	0	62,987		1.00
	TOTALS		0	62,987		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	42,455		1.00
	TOTALS		0	42,455		
500.00	Grand Total: Increases		518,659	2,512,318		500.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/19/2014 8:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-NH BLDG	1.01	0	7,905	9		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,163,635	9		2.00
3.00	NEW CAP REL COSTS-NH BLDG	1.01	0	6,379	9		3.00
	TOTALS		0	1,177,919			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	57,639	37,029	0		1.00
	TOTALS		57,639	37,029			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,560	9		1.00
	TOTALS		0	2,560			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	NURSING ADMINISTRATION	13.00	37,945	0	0		1.00
	TOTALS		37,945	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,136,138	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,136,138			
	F - TO RECLASS ACUTE AND NURSERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	156,889	19,194	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	158,629	19,407	0		2.00
	TOTALS		315,518	38,601			
	G - TO RECLASS BILLING AND TRANSCRIPTION						
1.00	CLINIC	90.00	0	10,555	0		1.00
	TOTALS		0	10,555			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	11,988	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	4,074	0		2.00
	TOTALS		11,988	4,074			
	I - TO RECLASS RHC TIME STUDY						
1.00	RURAL HEALTH CLINIC	88.00	95,569	0	0		1.00
	TOTALS		95,569	0			
	K - RECLASS ALLOWABLE PHYSICIAN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	62,987	0		1.00
	TOTALS		0	62,987			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,455	0		1.00
	TOTALS		0	42,455			
500.00	Grand Total: Decreases		518,659	2,512,318			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	521,757	0	0	0	0	1.00
2.00	Land Improvements	346,855	14,418	0	14,418	0	2.00
3.00	Buildings and Fixtures	24,007,277	756,718	0	756,718	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,360,648	196,326	0	196,326	0	6.00
7.00	HIT designated Assets	1,331,937	388,615	0	388,615	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,568,474	1,356,077	0	1,356,077	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,568,474	1,356,077	0	1,356,077	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	521,757	0	1.00
2.00	Land Improvements	361,273	0	2.00
3.00	Buildings and Fixtures	24,763,995	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,556,974	0	6.00
7.00	HIT designated Assets	1,720,552	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,924,551	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,924,551	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/19/2014 8:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,192,544	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	107,859	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	726,862	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,027,265	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,192,544	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	107,859	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	726,862	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	2.01
3.00	Total (sum of lines 1-2)	0	2,027,265	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/19/2014 8:22 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	361,273	0	361,273	0.010973	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	3,511,322	0	3,511,322	0.106648	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	21,774,693	0	21,774,693	0.661350	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,244,934	0	7,244,934	0.220047	0	2.00
2.01	NEW CAP REL COSTS-NH ME	32,329	0	32,329	0.000982	0	2.01
3.00	Total (sum of lines 1-2)	32,924,551	0	32,924,551	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	26,349	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	93,575	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,159,542	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	523,730	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	7,905	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,811,101	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	26,349	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	0	93,575	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,073,424	0	0	0	2,232,966	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,634	0	0	0	549,364	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	7,905	2.01
3.00	Total (sum of lines 1-2)	1,099,058	0	0	0	2,910,159	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/19/2014 8:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-NH BLDG (chapter 2)		0	NEW CAP REL COSTS-NH BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-NH ME (chapter 2)		0	NEW CAP REL COSTS-NH ME	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-4,093	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,258	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,819,740			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	-137,701			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-30,910	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,032	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,669	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-NH BLDG		0	NEW CAP REL COSTS-NH BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/19/2014 8:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.01	Depreciation - NEW CAP REL COSTS-NH ME		0	NEW CAP REL COSTS-NH ME	2.01	0	27.01
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-203,132	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENT INCOME	B	-29,256	CLINIC	90.00	0	33.00
34.00	DR SPACE	B	-2,025	CLINIC	90.00	0	34.00
35.00	IT MISC REVENUE	B	-639	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	LOBBYING	A	-8,923	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	36.00
37.00	NEUROLOGY RENT	B	-90	RESPIRATORY THERAPY	65.00	0	37.00
38.00	PHYS RECRUITMENT	A	-11,148	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-116,547	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	39.00
40.00	ADVERTSING- BOWEN	A	-2,297	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING - CLINIC	A	-8,316	CLINIC	90.00	0	41.00
42.00	SUPPLIES SOLD	A	-5,668	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-88,753	CLINIC	90.00	0	43.00
44.00	UNNECESSARY BORROWING	A	-17,691	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-28,217	CLINIC	90.00	0	45.00
45.01			0		0.00	0	45.01
45.02	RENTAL INCOME - MIDWEST	B	-1,532	CLINIC	90.00	0	45.02
45.03			0		0.00	0	45.03
45.04	MISC INCOME	B	-2,489	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.04
45.05	ADVERTISING - WOMENS	A	-7,465	RURAL HEALTH CLINIC	88.00	0	45.05
45.06			0		0.00	0	45.06
45.07	MISC INCOME - PRAIRIE CARDIOVASCULAR	B	-1,425	LABORATORY	60.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-2,886	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.08
45.09	RADIOLOGY	B	-565	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	PROVIDER TAX	A	-496,714	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.10
45.11			0		0.00	0	45.11
45.14			0		0.00	0	45.14
45.15	MARKETING SALARIES	A	-59,005	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.15
45.16	MARKETING FRINGES	A	-9,887	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.16
45.17			0		0.00	0	45.17
45.18	CITY OF CARTHAGE INTEREST	A	-15,573	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	45.18
45.19			0		0.00	0	45.19
45.20	GEROPHYSCH MEALS	B	-5,427	DIETARY	10.00	0	45.20
45.21			0		0.00	0	45.21
45.24	NURSING HOME RENTAL INCOME	B	-3,600	OTHER LONG TERM CARE	46.00	0	45.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,128,673				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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/19/2014 8:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7.00	OPERATION OF PLANT	RENT	0	102,266	1.00
2.00	88.00	RURAL HEALTH CLINIC	RENT	0	35,435	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	0	137,701	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141305	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/19/2014 8:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-102,266	0		1.00
2.00	-35,435	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-137,701			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/19/2014 8:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	56.00	RADIOISOTOPE	6,000	0	6,000	0	0	2.00
3.00	60.02	GEO PSYCH	26,535	26,535	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	18,000	0	18,000	0	0	4.00
5.00	90.00	CLINIC	1,427,535	1,427,535	0	0	0	5.00
6.00	91.00	EMERGENCY	1,674,028	291,616	1,382,412	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	74,054	74,054	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			3,250,152	1,819,740	1,430,412		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	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	60.00	LABORATORY	0	0	0	0		1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0		2.00
3.00	60.02	GEO PSYCH	0	0	0	26,535		3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0		4.00
5.00	90.00	CLINIC	0	0	0	1,427,535		5.00
6.00	91.00	EMERGENCY	0	0	0	291,616		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	74,054		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,819,740		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/19/2014 8:22 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	437.50	0.00	498.25	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.65	0.00	38.32	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)	38.33	38.33	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					33,534	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)					33,534	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					19,093	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)					52,627	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)					76.65	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					59,787	22.00
23.00	Total salary equivalency (see instructions)					78,880	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/19/2014 8:22 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.65	0.00	38.32	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)	78,880		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	78,880		63.00
64.00	Total cost of outside supplier services (from your records)	58,029		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	98.00	0.00	259.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.64	0.00	36.32	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)	36.32	36.32	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		7,119	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)		7,119	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		9,407	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)		16,526	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)		72.64	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		56,659	22.00
23.00	Total salary equivalency (see instructions)		66,066	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.64	0.00	36.32	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)		66,066	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		66,066	63.00
64.00	Total cost of outside supplier services (from your records)		21,105	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	85.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.90	34.90	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,933	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)					5,933	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)					5,933	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)					69.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,444	22.00
23.00	Total salary equivalency (see instructions)					54,444	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.80	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	54,444	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	54,444	63.00
64.00	Total cost of outside supplier services (from your records)	7,789	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	26,349	26,349				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	93,575	0	93,575			1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	2,232,966	0	0	2,232,966		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	549,364				549,364	2.00
2.01	00201	NEW CAP REL COSTS-NH ME	7,905				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,580,298	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	105,481	0	0	0	0	4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	1,287,539	9,145	7,440	536,340	159,602	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,289,896	0	6,569	0	0	5.02
7.00	00700	OPERATION OF PLANT	585,341	1,393	0	110,669	22,422	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	158,778	0	7,823	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	49,550	0	0	9,582	1,607	8.00
9.00	00900	HOUSEKEEPING	137,655	0	0	24,008	4,027	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	21,724	0	434	0	0	9.01
10.00	01000	DIETARY	133,806	0	0	45,384	7,612	10.00
11.00	01100	CAFETERIA	63,758	0	0	25,851	4,336	11.00
13.00	01300	NURSING ADMINISTRATION	150,031	0	0	13,952	2,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226,729	2,860	2,894	41,435	32,109	16.00
17.00	01700	SOCIAL SERVICE	37,945	0	0	9,214	1,545	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	410,945	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,220,274	0	0	515,016	86,393	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	178,036	0	0	11,846	1,987	43.00
46.00	04600	OTHER LONG TERM CARE	29,133	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	371,333	0	0	210,966	35,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,501	0	0	46,647	7,824	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,007,664	0	0	233,184	39,112	54.00
56.00	05600	RADIOISOTOPE	90,794	0	0	16,321	2,738	56.00
60.00	06000	LABORATORY	911,096	226	0	88,872	15,534	60.00
60.02	06002	GEO PSYCH	237,460	3,813	0	0	10,562	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,748	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	223,819	0	0	36,381	6,102	65.00
66.00	06600	PHYSICAL THERAPY	86,923	0	0	13,636	2,287	66.00
69.00	06900	ELECTROCARDIOLOGY	15,719	0	2,203	59,231	23,058	69.00
69.01	06901	PULMONARY REHAB	170,534	3,188	0	0	8,831	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	738,175	0	0	17,164	2,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,455	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	658,956	115	0	65,864	11,365	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,151,601	0	0	0	0	88.00
90.00	09000	CLINIC	540,283	4,872	0	0	13,494	90.00
91.00	09100	EMERGENCY	1,803,982	0	0	97,507	16,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	60,917	737	0	0	2,040	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,787,038	26,349	27,363	2,229,070	521,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	3,896	653	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	362,781	0	4,560	0	27,164	192.00
194.00	07950	NAUVOO APARTMENTS	21,480	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	61,652	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,171,299	26,349	93,575	2,232,966	549,364	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	EMPLOYEE BENEFITS DEPARTMENT	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	Subtotal	
			2.01	4.00	4.01	5.01	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME	7,905					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,580,298				4.00
4.01	00401	SHARED HUMAN RESOURCES	0	16,607	122,088			4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	0	94,246	7,305	2,101,617		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	679	207,295	16,417	190,612	1,711,468	5.02
7.00	00700	OPERATION OF PLANT	0	30,541	2,367	94,272	847,005	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	809	0	159	0	167,569	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	7,605	68,344	8.00
9.00	00900	HOUSEKEEPING	0	21,321	1,653	23,641	212,305	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	45	0	327	0	22,530	9.01
10.00	01000	DIETARY	0	18,226	1,413	26,543	232,984	10.00
11.00	01100	CAFETERIA	0	12,249	949	13,426	120,569	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,945	1,391	23,262	208,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,909	2,241	42,243	379,420	16.00
17.00	01700	SOCIAL SERVICE	0	8,064	625	7,193	64,586	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	82,851	6,422	62,708	562,926	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	251,721	19,505	262,273	2,355,182	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	33,712	2,613	28,603	256,797	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	29,133	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,028	4,575	85,355	766,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,879	688	13,973	125,512	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	89,160	6,911	172,366	1,548,397	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,754	123,607	56.00
60.00	06000	LABORATORY	0	94,117	7,295	167,740	1,284,880	60.00
60.02	06002	GEO PSYCH	0	17,304	1,341	33,133	303,613	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6,354	57,102	62.00
65.00	06500	RESPIRATORY THERAPY	0	35,026	2,772	38,107	342,207	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,876	115,722	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,548	197	12,893	115,849	69.00
69.01	06901	PULMONARY REHAB	0	8,191	635	23,969	215,348	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,417	575	68,155	834,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,315	47,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,252	2,345	96,296	865,193	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	157,612	12,216	165,596	1,487,025	88.00
90.00	09000	CLINIC	0	99,701	7,728	85,277	751,355	90.00
91.00	09100	EMERGENCY	0	68,428	5,304	249,413	2,240,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	12,190	945	9,631	86,460	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,533	1,513,540	116,914	2,042,584	18,551,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	570	5,119	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	66,758	5,174	58,463	524,900	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	21,480	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,372	0	0	0	68,024	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,905	1,580,298	122,088	2,101,617	19,171,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	1,711,468					5.02
7.00	00700	OPERATION OF PLANT	83,026	930,031				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	16,426	0	183,995			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	6,699	5,619	0	80,662		8.00
9.00	00900	HOUSEKEEPING	20,811	14,079	0	0	247,195	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	2,208	0	1,114	0	0	9.01
10.00	01000	DIETARY	22,838	26,614	0	0	7,227	10.00
11.00	01100	CAFETERIA	11,819	15,159	0	0	4,116	11.00
13.00	01300	NURSING ADMINISTRATION	20,479	8,182	0	0	2,222	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,192	24,298	7,422	0	6,598	16.00
17.00	01700	SOCIAL SERVICE	6,331	5,403	0	0	1,467	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	55,180	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	230,863	302,014	0	33,829	82,010	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	25,172	6,947	0	0	1,886	43.00
46.00	04600	OTHER LONG TERM CARE	2,856	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,149	123,714	0	19,829	33,594	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,303	27,355	0	0	7,428	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,779	136,743	0	11,978	37,132	54.00
56.00	05600	RADIOISOTOPE	12,116	9,571	0	0	2,599	56.00
60.00	06000	LABORATORY	125,948	52,116	0	23	14,152	60.00
60.02	06002	GEO PSYCH	29,761	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,597	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	33,544	21,334	0	306	5,793	65.00
66.00	06600	PHYSICAL THERAPY	11,343	7,996	0	0	2,171	66.00
69.00	06900	ELECTROCARDIOLOGY	11,356	34,734	5,650	0	9,432	69.00
69.01	06901	PULMONARY REHAB	21,109	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,787	10,065	0	0	2,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,683	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,809	38,624	0	0	10,488	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	145,763	0	0	1,171	0	88.00
90.00	09000	CLINIC	73,650	0	0	1,903	0	90.00
91.00	09100	EMERGENCY	219,668	57,179	0	11,575	15,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	8,475	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,650,740	927,746	14,186	80,614	246,575	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	502	2,285	0	0	620	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,452	0	11,696	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	2,106	0	0	48	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,668	0	158,113	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,711,468	930,031	183,995	80,662	247,195	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.01	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME	25,852					9.01
10.00	01000	DIETARY	0	289,663				10.00
11.00	01100	CAFETERIA	0	0	151,663			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	6,393	246,197		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,049	0	8,992	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,951	3,525	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	289,663	41,973	75,827	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	6,495	11,735	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	10,933	19,752	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,302	4,158	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	15,115	27,306	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	19,781	35,736	0	60.00
60.02	06002	GEO PSYCH	0	0	5,353	9,670	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	7,813	14,115	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	799	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	2,524	4,560	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,698	3,068	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	3,979	7,188	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	14,053	25,389	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	2,307	4,168	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,848	289,663	151,663	246,197	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,653	0	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	22,351	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,852	289,663	151,663	246,197	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	464,971				16.00
17.00	01700	SOCIAL SERVICE	0	0	77,788			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	623,582		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	37,184	76,232	0	3,524,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,697	0	0	310,729	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	31,989	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,383	0	0	1,078,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,884	0	0	180,942	52.00
53.00	05300	ANESTHESIOLOGY	0	20,651	0	623,582	644,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	108,728	0	0	2,037,178	54.00
56.00	05600	RADIOISOTOPE	0	7,559	0	0	155,452	56.00
60.00	06000	LABORATORY	0	110,617	0	0	1,643,253	60.00
60.02	06002	GEO PSYCH	0	7,534	0	0	355,931	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,226	0	0	63,925	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,063	0	0	434,175	65.00
66.00	06600	PHYSICAL THERAPY	0	3,725	0	0	140,957	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,634	0	0	184,454	69.00
69.01	06901	PULMONARY REHAB	0	4,062	0	0	247,603	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,033	0	0	950,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,258	0	0	53,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,655	0	0	1,032,936	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	32,035	0	0	1,665,994	88.00
90.00	09000	CLINIC	0	9,765	0	0	836,673	90.00
91.00	09100	EMERGENCY	0	28,412	1,556	0	2,614,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	490	0	0	101,900	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	461,595	77,788	623,582	18,290,906	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,526	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,376	0	0	593,077	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	23,634	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	255,156	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	464,971	77,788	623,582	19,171,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-NH ME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	SHARED HUMAN RESOURCES				4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING NURSING HOME				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,524,777		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	310,729		43.00
46.00	04600	OTHER LONG TERM CARE	0	31,989		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,078,997		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	180,942		52.00
53.00	05300	ANESTHESIOLOGY	0	644,233		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,037,178		54.00
56.00	05600	RADIOISOTOPE	0	155,452		56.00
60.00	06000	LABORATORY	0	1,643,253		60.00
60.02	06002	GEO PSYCH	0	355,931		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	63,925		62.00
65.00	06500	RESPIRATORY THERAPY	0	434,175		65.00
66.00	06600	PHYSICAL THERAPY	0	140,957		66.00
69.00	06900	ELECTROCARDIOLOGY	0	184,454		69.00
69.01	06901	PULMONARY REHAB	0	247,603		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	950,749		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	53,711		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,032,936		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,665,994		88.00
90.00	09000	CLINIC	0	836,673		90.00
91.00	09100	EMERGENCY	0	2,614,348		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	101,900		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,290,906		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,526		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	593,077		192.00
194.00	07950	NAUVOO APARTMENTS	0	23,634		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	255,156		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	19,171,299		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	0	9,145	7,440	536,340	159,602	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	6,569	0	0	5.02
7.00	00700	OPERATION OF PLANT	0	1,393	0	110,669	22,422	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	0	7,823	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	9,582	1,607	8.00
9.00	00900	HOUSEKEEPING	0	0	0	24,008	4,027	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	0	434	0	0	9.01
10.00	01000	DIETARY	0	0	0	45,384	7,612	10.00
11.00	01100	CAFETERIA	0	0	0	25,851	4,336	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13,952	2,340	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,860	2,894	41,435	32,109	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	9,214	1,545	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	515,016	86,393	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	11,846	1,987	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	210,966	35,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	46,647	7,824	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	233,184	39,112	54.00
56.00	05600	RADIOISOTOPE	0	0	0	16,321	2,738	56.00
60.00	06000	LABORATORY	0	226	0	88,872	15,534	60.00
60.02	06002	GEO PSYCH	0	3,813	0	0	10,562	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	36,381	6,102	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,636	2,287	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,203	59,231	23,058	69.00
69.01	06901	PULMONARY REHAB	0	3,188	0	0	8,831	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,164	2,879	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	115	0	65,864	11,365	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	4,872	0	0	13,494	90.00
91.00	09100	EMERGENCY	0	0	0	97,507	16,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	737	0	0	2,040	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	26,349	27,363	2,229,070	521,547	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	3,896	653	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,560	0	27,164	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	61,652	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	26,349	93,575	2,232,966	549,364	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	
			2.01	2A	4.00	4.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0		4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	0	712,527	0	0	712,527	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	679	7,248	0	0	64,625	5.02
7.00	00700	OPERATION OF PLANT	0	134,484	0	0	31,962	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	809	8,632	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,189	0	0	2,578	8.00
9.00	00900	HOUSEKEEPING	0	28,035	0	0	8,015	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	45	479	0	0	0	9.01
10.00	01000	DIETARY	0	52,996	0	0	8,999	10.00
11.00	01100	CAFETERIA	0	30,187	0	0	4,552	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,292	0	0	7,887	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,298	0	0	14,322	16.00
17.00	01700	SOCIAL SERVICE	0	10,759	0	0	2,439	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	21,260	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	601,409	0	0	88,919	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	13,833	0	0	9,697	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	246,352	0	0	28,939	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	54,471	0	0	4,738	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	272,296	0	0	58,439	54.00
56.00	05600	RADIOISOTOPE	0	19,059	0	0	4,663	56.00
60.00	06000	LABORATORY	0	104,632	0	0	56,870	60.00
60.02	06002	GEO PSYCH	0	14,375	0	0	11,233	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	2,154	62.00
65.00	06500	RESPIRATORY THERAPY	0	42,483	0	0	12,920	65.00
66.00	06600	PHYSICAL THERAPY	0	15,923	0	0	4,366	66.00
69.00	06900	ELECTROCARDIOLOGY	0	84,492	0	0	4,371	69.00
69.01	06901	PULMONARY REHAB	0	12,019	0	0	8,126	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,043	0	0	23,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	77,344	0	0	32,648	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	56,144	88.00
90.00	09000	CLINIC	0	18,366	0	0	28,912	90.00
91.00	09100	EMERGENCY	0	113,862	0	0	84,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	2,777	0	0	3,265	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,533	2,805,862	0	0	692,513	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,549	0	0	193	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,724	0	0	19,821	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	6,372	68,024	0	0	0	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,905	2,910,159	0	0	712,527	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.02	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	71,873					5.02
7.00	00700	OPERATION OF PLANT	3,486	169,932				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	690	0	9,322			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	281	1,027	0	15,075		8.00
9.00	00900	HOUSEKEEPING	874	2,572	0	0	39,496	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	93	0	56	0	0	9.01
10.00	01000	DIETARY	959	4,863	0	0	1,155	10.00
11.00	01100	CAFETERIA	496	2,770	0	0	658	11.00
13.00	01300	NURSING ADMINISTRATION	860	1,495	0	0	355	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,562	4,440	376	0	1,054	16.00
17.00	01700	SOCIAL SERVICE	266	987	0	0	234	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,317	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,700	55,184	0	6,322	13,103	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,057	1,269	0	0	301	43.00
46.00	04600	OTHER LONG TERM CARE	120	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,156	22,605	0	3,706	5,367	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	517	4,998	0	0	1,187	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,373	24,985	0	2,239	5,933	54.00
56.00	05600	RADIOISOTOPE	509	1,749	0	0	415	56.00
60.00	06000	LABORATORY	5,289	9,522	0	4	2,261	60.00
60.02	06002	GEO PSYCH	1,250	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	235	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,409	3,898	0	57	926	65.00
66.00	06600	PHYSICAL THERAPY	476	1,461	0	0	347	66.00
69.00	06900	ELECTROCARDIOLOGY	477	6,346	286	0	1,507	69.00
69.01	06901	PULMONARY REHAB	886	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,434	1,839	0	0	437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,561	7,057	0	0	1,676	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,121	0	0	219	0	88.00
90.00	09000	CLINIC	3,093	0	0	356	0	90.00
91.00	09100	EMERGENCY	9,224	10,448	0	2,163	2,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	356	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,324	169,515	718	15,066	39,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21	417	0	0	99	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,160	0	593	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	88	0	0	9	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	280	0	8,011	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	71,873	169,932	9,322	15,075	39,496	202.00

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		Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.01	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME	628					9.01
10.00	01000	DIETARY	0	68,972				10.00
11.00	01100	CAFETERIA	0	0	38,663			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,630	28,519		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25	0	2,292	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	497	408	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	68,972	10,699	8,784	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,656	1,359	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,787	2,288	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	587	482	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,853	3,163	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	5,043	4,140	0	60.00
60.02	06002	GEO PSYCH	0	0	1,365	1,120	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,992	1,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	644	528	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	433	355	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,014	833	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	3,583	2,941	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	588	483	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44	68,972	38,663	28,519	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	40	0	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	544	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	628	68,972	38,663	28,519	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	103,369				16.00
17.00	01700	SOCIAL SERVICE	0	0	14,685			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	24,482		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,266	14,391		885,749	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	377	0		29,549	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		120	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,532	0		321,732	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	419	0		67,399	52.00
53.00	05300	ANESTHESIOLOGY	0	4,591	0		4,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,171	0		401,452	54.00
56.00	05600	RADIOISOTOPE	0	1,680	0		28,075	56.00
60.00	06000	LABORATORY	0	24,595	0		212,356	60.00
60.02	06002	GEO PSYCH	0	1,675	0		31,018	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	273	0		2,662	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,015	0		67,335	65.00
66.00	06600	PHYSICAL THERAPY	0	828	0		23,401	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,475	0		98,973	69.00
69.01	06901	PULMONARY REHAB	0	903	0		23,106	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,786	0		53,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	280	0		2,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,036	0		129,169	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,121	0		69,605	88.00
90.00	09000	CLINIC	0	2,171	0		52,898	90.00
91.00	09100	EMERGENCY	0	6,316	294		235,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04042	DIABETIC EDUCATION	0	109	0		7,578	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	102,619	14,685	0	2,748,354	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		5,279	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	750	0		55,088	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		97	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0		76,859	194.03
200.00		Cross Foot Adjustments				24,482	24,482	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	103,369	14,685	24,482	2,910,159	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-NH ME				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
4.01	00401	SHARED HUMAN RESOURCES				4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT NURSING HOME				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING NURSING HOME				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	885,749		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	29,549		43.00
46.00	04600	OTHER LONG TERM CARE	0	120		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	321,732		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	67,399		52.00
53.00	05300	ANESTHESIOLOGY	0	4,591		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	401,452		54.00
56.00	05600	RADIOISOTOPE	0	28,075		56.00
60.00	06000	LABORATORY	0	212,356		60.00
60.02	06002	GEO PSYCH	0	31,018		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,662		62.00
65.00	06500	RESPIRATORY THERAPY	0	67,335		65.00
66.00	06600	PHYSICAL THERAPY	0	23,401		66.00
69.00	06900	ELECTROCARDIOLOGY	0	98,973		69.00
69.01	06901	PULMONARY REHAB	0	23,106		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	53,434		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,279		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	129,169		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	69,605		88.00
90.00	09000	CLINIC	0	52,898		90.00
91.00	09100	EMERGENCY	0	235,873		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	7,578		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,748,354		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,279		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	55,088		192.00
194.00	07950	NAUVOO APARTMENTS	0	97		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	76,859		194.03
200.00		Cross Foot Adjustments	0	24,482		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,910,159		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (OLD HOSP/PBC SQUARE)	NEW NH BLDG (NH/MSS SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	NEW MVBLE EQUIP (HOSP SQUARE FEET)	NEW NH ME (NH SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,264					1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG	0	63,117				1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	42,412			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				62,209		2.00
2.01	00201	NEW CAP REL COSTS-NH ME				0	51,585	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
4.01	00401	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	2,868	5,018	10,187	18,073	0	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	0	4,431	0	0	4,431	5.02
7.00	00700	OPERATION OF PLANT	437	0	2,102	2,539	0	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	5,277	0	0	5,277	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	182	182	0	8.00
9.00	00900	HOUSEKEEPING	0	0	456	456	0	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	293	0	0	293	9.01
10.00	01000	DIETARY	0	0	862	862	0	10.00
11.00	01100	CAFETERIA	0	0	491	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	265	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	1,952	787	3,636	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	175	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,782	9,783	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	225	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,007	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	886	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,429	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	310	310	0	56.00
60.00	06000	LABORATORY	71	0	1,688	1,759	0	60.00
60.02	06002	GEO PSYCH	1,196	0	0	1,196	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	691	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	259	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,486	1,125	2,611	0	69.00
69.01	06901	PULMONARY REHAB	1,000	0	0	1,000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	326	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36	0	1,251	1,287	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,528	0	0	1,528	0	90.00
91.00	09100	EMERGENCY	0	0	1,852	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	231	0	0	231	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,264	18,457	42,338	59,059	10,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	74	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	3,076	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	41,584	0	0	41,584	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	26,349	93,575	2,232,966	549,364	7,905	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.188408	1.482564	52.649392	8.830941	0.153242	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/19/2014 8:22 am

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (HOSPITAL SALARIES)	SHARED HUMAN RESOURCES (HOSP/NH GROSS SAL)	HOSPITAL ONLY BUS OFF AND A&G (HOSP ONLY ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			4.00	4.01	5.01	5A.02	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,436,014					4.00
4.01	00401	SHARED HUMAN RESOURCES	78,141	7,412,067				4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G	443,467	443,467	16,785,984			5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	975,414	996,656	1,522,451	-1,711,468	17,459,831	5.02
7.00	00700	OPERATION OF PLANT	143,707	143,707	752,968	0	847,005	7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	9,640	0	0	167,569	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	60,739	0	68,344	8.00
9.00	00900	HOUSEKEEPING	100,323	100,323	188,827	0	212,305	9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	19,825	0	0	22,530	9.01
10.00	01000	DIETARY	85,759	85,759	212,007	0	232,984	10.00
11.00	01100	CAFETERIA	57,639	57,639	107,238	0	120,569	11.00
13.00	01300	NURSING ADMINISTRATION	84,437	84,437	185,796	0	208,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,030	136,030	337,399	0	379,420	16.00
17.00	01700	SOCIAL SERVICE	37,945	37,945	57,455	0	64,586	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	389,852	389,852	500,855	0	562,926	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,184,491	1,184,491	2,094,853	0	2,355,182	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	158,629	158,629	228,453	0	256,797	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	29,133	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	277,752	277,752	681,742	0	766,643	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,780	41,780	111,608	0	125,512	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,539	419,539	1,376,717	0	1,548,397	54.00
56.00	05600	RADIOISOTOPE	0	0	109,853	0	123,607	56.00
60.00	06000	LABORATORY	442,861	442,861	1,339,762	0	1,284,880	60.00
60.02	06002	GEO PSYCH	81,423	81,423	264,640	0	303,613	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	50,748	0	57,102	62.00
65.00	06500	RESPIRATORY THERAPY	164,813	168,300	304,370	0	342,207	65.00
66.00	06600	PHYSICAL THERAPY	0	0	102,846	0	115,722	66.00
69.00	06900	ELECTROCARDIOLOGY	11,988	11,988	102,976	0	115,849	69.00
69.01	06901	PULMONARY REHAB	38,544	38,544	191,443	0	215,348	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,898	34,898	544,367	0	834,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	42,455	0	47,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,348	142,348	769,129	0	865,193	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	741,632	741,632	1,322,642	0	1,487,025	88.00
90.00	09000	CLINIC	469,137	469,137	681,121	0	751,355	90.00
91.00	09100	EMERGENCY	321,982	321,982	1,992,102	0	2,240,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	57,357	57,357	76,922	0	86,460	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,121,888	7,097,941	16,314,484	-1,711,468	16,840,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,549	0	5,119	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,126	314,126	466,951	0	524,900	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	21,480	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	68,024	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,580,298	122,088	2,101,617		1,711,468	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.212520	0.016472	0.125201		0.098023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	712,527		71,873	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.042448		0.004116	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT NURSING HOME (NH/MSS SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOSP ONLY SQUARE FT)	HOUSEKEEPING NURSING HOME (NH/MSS SQUARE FEET)	
			7.00	7.01	8.00	9.00	9.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT	30,123					7.00
7.01	00701	OPERATION OF PLANT NURSING HOME	0	48,391				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	182	0	80,130			8.00
9.00	00900	HOUSEKEEPING	456	0	0	29,485		9.00
9.01	00901	HOUSEKEEPING NURSING HOME	0	293	0	0	48,098	9.01
10.00	01000	DIETARY	862	0	0	862	0	10.00
11.00	01100	CAFETERIA	491	0	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	265	0	0	265	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	787	1,952	0	787	1,952	16.00
17.00	01700	SOCIAL SERVICE	175	0	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,782	0	33,606	9,782	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	225	0	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,007	0	19,698	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	886	0	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,429	0	11,899	4,429	0	54.00
56.00	05600	RADIOISOTOPE	310	0	0	310	0	56.00
60.00	06000	LABORATORY	1,688	0	23	1,688	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	691	0	304	691	0	65.00
66.00	06600	PHYSICAL THERAPY	259	0	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,125	1,486	0	1,125	1,486	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	326	0	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,251	0	0	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,163	0	0	88.00
90.00	09000	CLINIC	0	0	1,890	0	0	90.00
91.00	09100	EMERGENCY	1,852	0	11,499	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,049	3,731	80,082	29,411	3,438	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74	0	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	0	3,076	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	48	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	41,584	0	0	41,584	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	930,031	183,995	80,662	247,195	25,852	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.874448	3.802257	1.006639	8.383754	0.537486	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	169,932	9,322	15,075	39,496	628	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.641271	0.192639	0.188132	1.339529	0.013057	205.00

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		Cost Center Description	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG						1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-NH ME						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	SHARED HUMAN RESOURCES						4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT NURSING HOME						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING NURSING HOME						9.01
10.00	01000	DIETARY	2,105					10.00
11.00	01100	CAFETERIA	0	162,159				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,835	145,709			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,614	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,086	2,086	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,105	44,877	44,877	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	6,945	6,945	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,690	11,690	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,461	2,461	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,161	16,161	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	21,150	21,150	0	0	60.00
60.02	06002	GEO PSYCH	0	5,723	5,723	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,354	8,354	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	2,699	2,699	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,816	1,816	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,254	4,254	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,026	15,026	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	2,467	2,467	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,105	162,159	145,709	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	289,663	151,663	246,197	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	137.607126	0.935273	1.689649	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,972	38,663	28,519	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	32.765796	0.238426	0.195726	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/19/2014 8:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-NH BLDG					1.01
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-NH ME					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	SHARED HUMAN RESOURCES					4.01
5.01	00550	HOSPITAL ONLY BUS OFF AND A&G					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT NURSING HOME					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING NURSING HOME					9.01
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,257,296				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,659,589	98			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
43.00	04300	NURSERY	121,411	0			43.00
46.00	04600	OTHER LONG TERM CARE	0	0			46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,101,668	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,790	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,477,051	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,776,872	0	0		54.00
56.00	05600	RADIOISOTOPE	540,688	0	0		56.00
60.00	06000	LABORATORY	7,911,737	0	0		60.00
60.02	06002	GEO PSYCH	538,869	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	87,696	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	648,259	0	0		65.00
66.00	06600	PHYSICAL THERAPY	266,464	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	474,494	0	0		69.00
69.01	06901	PULMONARY REHAB	290,535	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,218,304	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,954	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,620,397	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,291,340	0	0		88.00
90.00	09000	CLINIC	698,475	0	0		90.00
91.00	09100	EMERGENCY	2,032,191	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	35,063	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,015,847	100	2,080		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	241,449	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0	0		194.02
194.03	07953	VACANT SPACE - OLD NURSING HOME	0	0	0		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	464,971	77,788	623,582		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013981	777.880000	299.799038		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	103,369	14,685	24,482		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003108	146.850000	11.770192		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,524,777		3,524,777	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	310,729		310,729	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	31,989		31,989	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,997		1,078,997	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,942		180,942	0	0	52.00
53.00	05300	ANESTHESIOLOGY	644,233		644,233	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,037,178		2,037,178	0	0	54.00
56.00	05600	RADIOISOTOPE	155,452		155,452	0	0	56.00
60.00	06000	LABORATORY	1,643,253		1,643,253	0	0	60.00
60.02	06002	GEO PSYCH	355,931		355,931	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,925		63,925	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	434,175	0	434,175	0	0	65.00
66.00	06600	PHYSICAL THERAPY	140,957	0	140,957	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	184,454		184,454	0	0	69.00
69.01	06901	PULMONARY REHAB	247,603		247,603	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950,749		950,749	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,711		53,711	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,936		1,032,936	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,665,994		1,665,994	0	0	88.00
90.00	09000	CLINIC	836,673		836,673	0	0	90.00
91.00	09100	EMERGENCY	2,614,348		2,614,348	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,872		475,872		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,900		101,900	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,766,778	0	18,766,778	0	0	200.00
201.00		Less Observation Beds	475,872		475,872		0	201.00
202.00		Total (see instructions)	18,290,906	0	18,290,906	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,951,889		1,951,889			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	121,411		121,411			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	697,233	1,404,435	2,101,668	0.513400	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,330	460	134,790	1.342399	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	465,383	1,011,668	1,477,051	0.436162	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,482	7,092,390	7,776,872	0.261953	0.000000	54.00
56.00	05600	RADIOISOTOPE	37,389	503,299	540,688	0.287508	0.000000	56.00
60.00	06000	LABORATORY	884,761	7,026,976	7,911,737	0.207698	0.000000	60.00
60.02	06002	GEO PSYCH	0	538,869	538,869	0.660515	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	40,744	46,952	87,696	0.728939	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	205,162	443,097	648,259	0.669755	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	265,126	1,338	266,464	0.528991	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	28,363	446,131	474,494	0.388738	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	290,535	290,535	0.852231	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	819,381	398,923	1,218,304	0.780387	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,000	66,954	89,954	0.597094	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,746	1,089,651	1,620,397	0.637459	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,291,340	2,291,340			88.00
90.00	09000	CLINIC	100	698,375	698,475	1.197857	0.000000	90.00
91.00	09100	EMERGENCY	17,828	2,014,363	2,032,191	1.286468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,199	684,501	707,700	0.672421	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04042	DIABETIC EDUCATION	0	35,063	35,063	2.906197	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,930,527	26,085,320	33,015,847			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,930,527	26,085,320	33,015,847			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,524,777		3,524,777	0	3,524,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	310,729		310,729	0	310,729	43.00
46.00	04600	OTHER LONG TERM CARE	31,989		31,989	0	31,989	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,997		1,078,997	0	1,078,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,942		180,942	0	180,942	52.00
53.00	05300	ANESTHESIOLOGY	644,233		644,233	0	644,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,037,178		2,037,178	0	2,037,178	54.00
56.00	05600	RADIOISOTOPE	155,452		155,452	0	155,452	56.00
60.00	06000	LABORATORY	1,643,253		1,643,253	0	1,643,253	60.00
60.02	06002	GEO PSYCH	355,931		355,931	0	355,931	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,925		63,925	0	63,925	62.00
65.00	06500	RESPIRATORY THERAPY	434,175	0	434,175	0	434,175	65.00
66.00	06600	PHYSICAL THERAPY	140,957	0	140,957	0	140,957	66.00
69.00	06900	ELECTROCARDIOLOGY	184,454		184,454	0	184,454	69.00
69.01	06901	PULMONARY REHAB	247,603		247,603	0	247,603	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950,749		950,749	0	950,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,711		53,711	0	53,711	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,936		1,032,936	0	1,032,936	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,665,994		1,665,994	0	1,665,994	88.00
90.00	09000	CLINIC	836,673		836,673	0	836,673	90.00
91.00	09100	EMERGENCY	2,614,348		2,614,348	0	2,614,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,872		475,872		475,872	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,900		101,900	0	101,900	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,766,778	0	18,766,778	0	18,766,778	200.00
201.00		Less Observation Beds	475,872		475,872		475,872	201.00
202.00		Total (see instructions)	18,290,906	0	18,290,906	0	18,290,906	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,951,889		1,951,889			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	121,411		121,411			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	697,233	1,404,435	2,101,668	0.513400	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	134,330	460	134,790	1.342399	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	465,383	1,011,668	1,477,051	0.436162	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,482	7,092,390	7,776,872	0.261953	0.000000	54.00
56.00	05600	RADIOISOTOPE	37,389	503,299	540,688	0.287508	0.000000	56.00
60.00	06000	LABORATORY	884,761	7,026,976	7,911,737	0.207698	0.000000	60.00
60.02	06002	GEO PSYCH	0	538,869	538,869	0.660515	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	40,744	46,952	87,696	0.728939	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	205,162	443,097	648,259	0.669755	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	265,126	1,338	266,464	0.528991	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	28,363	446,131	474,494	0.388738	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	290,535	290,535	0.852231	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	819,381	398,923	1,218,304	0.780387	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,000	66,954	89,954	0.597094	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,746	1,089,651	1,620,397	0.637459	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,291,340	2,291,340	0.727083	0.000000	88.00
90.00	09000	CLINIC	100	698,375	698,475	1.197857	0.000000	90.00
91.00	09100	EMERGENCY	17,828	2,014,363	2,032,191	1.286468	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,199	684,501	707,700	0.672421	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04042	DIABETIC EDUCATION	0	35,063	35,063	2.906197	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,930,527	26,085,320	33,015,847			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,930,527	26,085,320	33,015,847			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.513400		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.342399		52.00
53.00	05300	ANESTHESIOLOGY	0.436162		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261953		54.00
56.00	05600	RADIOISOTOPE	0.287508		56.00
60.00	06000	LABORATORY	0.207698		60.00
60.02	06002	GEO PSYCH	0.660515		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728939		62.00
65.00	06500	RESPIRATORY THERAPY	0.669755		65.00
66.00	06600	PHYSICAL THERAPY	0.528991		66.00
69.00	06900	ELECTROCARDIOLOGY	0.388738		69.00
69.01	06901	PULMONARY REHAB	0.852231		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780387		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597094		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637459		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.727083		88.00
90.00	09000	CLINIC	1.197857		90.00
91.00	09100	EMERGENCY	1.286468		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672421		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.01	04042	DIABETIC EDUCATION	2.906197		93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,997	321,732	757,265	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,942	67,399	113,543	0	0	52.00
53.00	05300	ANESTHESIOLOGY	644,233	4,591	639,642	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,037,178	401,452	1,635,726	0	0	54.00
56.00	05600	RADIOISOTOPE	155,452	28,075	127,377	0	0	56.00
60.00	06000	LABORATORY	1,643,253	212,356	1,430,897	0	0	60.00
60.02	06002	GEO PSYCH	355,931	31,018	324,913	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,925	2,662	61,263	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	434,175	67,335	366,840	0	0	65.00
66.00	06600	PHYSICAL THERAPY	140,957	23,401	117,556	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	184,454	98,973	85,481	0	0	69.00
69.01	06901	PULMONARY REHAB	247,603	23,106	224,497	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950,749	53,434	897,315	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,711	2,279	51,432	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,936	129,169	903,767	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,665,994	69,605	1,596,389	0	0	88.00
90.00	09000	CLINIC	836,673	52,898	783,775	0	0	90.00
91.00	09100	EMERGENCY	2,614,348	235,873	2,378,475	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,872	173,519	302,353	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	101,900	7,578	94,322	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,899,283	2,006,455	12,892,828	0	0	200.00
201.00		Less Observation Beds	475,872	173,519	302,353	0	0	201.00
202.00		Total (line 200 minus line 201)	14,423,411	1,832,936	12,590,475	0	0	202.00

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

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,078,997	2,101,668	0.513400		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	180,942	134,790	1.342399		52.00
53.00	05300	ANESTHESIOLOGY	644,233	1,477,051	0.436162		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,037,178	7,776,872	0.261953		54.00
56.00	05600	RADIOISOTOPE	155,452	540,688	0.287508		56.00
60.00	06000	LABORATORY	1,643,253	7,911,737	0.207698		60.00
60.02	06002	GEO PSYCH	355,931	538,869	0.660515		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,925	87,696	0.728939		62.00
65.00	06500	RESPIRATORY THERAPY	434,175	648,259	0.669755		65.00
66.00	06600	PHYSICAL THERAPY	140,957	266,464	0.528991		66.00
69.00	06900	ELECTROCARDIOLOGY	184,454	474,494	0.388738		69.00
69.01	06901	PULMONARY REHAB	247,603	290,535	0.852231		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	950,749	1,218,304	0.780387		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	53,711	89,954	0.597094		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,936	1,620,397	0.637459		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,665,994	2,291,340	0.727083		88.00
90.00	09000	CLINIC	836,673	698,475	1.197857		90.00
91.00	09100	EMERGENCY	2,614,348	2,032,191	1.286468		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	475,872	707,700	0.672421		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04042	DIABETIC EDUCATION	101,900	35,063	2.906197		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	14,899,283	30,942,547			200.00
201.00		Less Observation Beds	475,872	0			201.00
202.00		Total (line 200 minus line 201)	14,423,411	30,942,547			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	321,732	2,101,668	0.153084	119,884	18,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,399	134,790	0.500030	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,591	1,477,051	0.003108	73,475	228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	401,452	7,776,872	0.051621	405,976	20,957	54.00
56.00	05600	RADIOISOTOPE	28,075	540,688	0.051925	21,783	1,131	56.00
60.00	06000	LABORATORY	212,356	7,911,737	0.026841	313,859	8,424	60.00
60.02	06002	GEO PSYCH	31,018	538,869	0.057561	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,662	87,696	0.030355	28,273	858	62.00
65.00	06500	RESPIRATORY THERAPY	67,335	648,259	0.103871	104,206	10,824	65.00
66.00	06600	PHYSICAL THERAPY	23,401	266,464	0.087820	40,071	3,519	66.00
69.00	06900	ELECTROCARDIOLOGY	98,973	474,494	0.208586	20,473	4,270	69.00
69.01	06901	PULMONARY REHAB	23,106	290,535	0.079529	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,434	1,218,304	0.043859	300,108	13,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,279	89,954	0.025335	22,191	562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,169	1,620,397	0.079714	201,350	16,050	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,605	2,291,340	0.030377	0	0	88.00
90.00	09000	CLINIC	52,898	698,475	0.075734	35	3	90.00
91.00	09100	EMERGENCY	235,873	2,032,191	0.116068	1,232	143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	173,519	707,700	0.245187	2,329	571	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	7,578	35,063	0.216125	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,006,455	30,942,547		1,655,245	99,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	623,582	0	0	0	623,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	623,582	0	0	0	623,582	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,101,668	0.000000	0.000000	119,884	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	134,790	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,477,051	0.422180	0.000000	73,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,776,872	0.000000	0.000000	405,976	54.00
56.00	05600	RADIOISOTOPE	0	540,688	0.000000	0.000000	21,783	56.00
60.00	06000	LABORATORY	0	7,911,737	0.000000	0.000000	313,859	60.00
60.02	06002	GEO PSYCH	0	538,869	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	87,696	0.000000	0.000000	28,273	62.00
65.00	06500	RESPIRATORY THERAPY	0	648,259	0.000000	0.000000	104,206	65.00
66.00	06600	PHYSICAL THERAPY	0	266,464	0.000000	0.000000	40,071	66.00
69.00	06900	ELECTROCARDIOLOGY	0	474,494	0.000000	0.000000	20,473	69.00
69.01	06901	PULMONARY REHAB	0	290,535	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,218,304	0.000000	0.000000	300,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,954	0.000000	0.000000	22,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,620,397	0.000000	0.000000	201,350	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,291,340	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	698,475	0.000000	0.000000	35	90.00
91.00	09100	EMERGENCY	0	2,032,191	0.000000	0.000000	1,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	707,700	0.000000	0.000000	2,329	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04042	DIABETIC EDUCATION	0	35,063	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	30,942,547			1,655,245	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	31,020	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	31,020	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.513400	0	446,956	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.342399	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.436162	0	322,329	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261953	0	2,562,749	0	0	54.00
56.00	05600	RADIOISOTOPE	0.287508	0	241,160	0	0	56.00
60.00	06000	LABORATORY	0.207698	0	2,666,569	0	0	60.00
60.02	06002	GEO PSYCH	0.660515	0	488,205	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728939	0	35,503	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.669755	0	188,248	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.528991	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.388738	0	197,000	0	0	69.00
69.01	06901	PULMONARY REHAB	0.852231	0	263,853	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780387	0	152,836	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597094	0	32,230	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637459	0	559,600	13,459	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.197857	0	161,433	0	0	90.00
91.00	09100	EMERGENCY	1.286468	0	708,913	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672421	0	257,635	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.906197	0	12,899	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	9,298,118	13,459	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,298,118	13,459	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	229,467	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	140,588	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	671,320	0		54.00
56.00	05600	RADIOISOTOPE	69,335	0		56.00
60.00	06000	LABORATORY	553,841	0		60.00
60.02	06002	GEO PSYCH	322,467	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	25,880	0		62.00
65.00	06500	RESPIRATORY THERAPY	126,080	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	76,581	0		69.00
69.01	06901	PULMONARY REHAB	224,864	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,271	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,244	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,722	8,580		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	193,374	0		90.00
91.00	09100	EMERGENCY	911,994	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	173,239	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	37,487	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,251,754	8,580		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,251,754	8,580		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/19/2014 8:22 am

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

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.513400	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.342399	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.436162	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261953	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.287508	0	0	0	0	56.00
60.00	06000	LABORATORY	0.207698	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.660515	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728939	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.669755	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.528991	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.388738	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.852231	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780387	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597094	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637459	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.197857	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.286468	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672421	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.906197	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GEO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04042	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	885,749	274,747	611,002	1,659	368.30	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	29,549		29,549	283	104.41	43.00
200.00	Total (lines 30-199)	915,298		640,551	1,942		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	288	106,070				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	179	18,689				43.00
200.00	Total (lines 30-199)	467	124,759				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	321,732	2,101,668	0.153084	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,399	134,790	0.500030	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,591	1,477,051	0.003108	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	401,452	7,776,872	0.051621	0	0	54.00
56.00	05600	RADIOISOTOPE	28,075	540,688	0.051925	0	0	56.00
60.00	06000	LABORATORY	212,356	7,911,737	0.026841	0	0	60.00
60.02	06002	GEO PSYCH	31,018	538,869	0.057561	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,662	87,696	0.030355	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	67,335	648,259	0.103871	0	0	65.00
66.00	06600	PHYSICAL THERAPY	23,401	266,464	0.087820	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	98,973	474,494	0.208586	0	0	69.00
69.01	06901	PULMONARY REHAB	23,106	290,535	0.079529	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,434	1,218,304	0.043859	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,279	89,954	0.025335	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,169	1,620,397	0.079714	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,605	2,291,340	0.030377	0	0	88.00
90.00	09000	CLINIC	52,898	698,475	0.075734	0	0	90.00
91.00	09100	EMERGENCY	235,873	2,032,191	0.116068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	173,520	707,700	0.245189	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	7,578	35,063	0.216125	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,006,456	30,942,547		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,659	0.00	288	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
43.00	04300	NURSERY	283	0.00	179	0		43.00
200.00		Total (lines 30-199)	1,942		467	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	623,582	0	0	0	623,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04042	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	623,582	0	0	0	623,582	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,101,668	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	134,790	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,477,051	0.422180	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,776,872	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	540,688	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	7,911,737	0.000000	0.000000	0	60.00
60.02	06002	GEO PSYCH	0	538,869	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	87,696	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	648,259	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	266,464	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	474,494	0.000000	0.000000	0	69.00
69.01	06901	PULMONARY REHAB	0	290,535	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,218,304	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,954	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,620,397	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,291,340	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	698,475	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,032,191	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	707,700	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04042	DIABETIC EDUCATION	0	35,063	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	30,942,547			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,659	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,334	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	350	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)	396	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	25	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)	743	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)	327	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)	353	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	136.58	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,524,777	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)	3,315	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)	1,095,631	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,429,146	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,429,146	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,464.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,087,923	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,087,923	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	769,945	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,857,868	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)	478,803	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	516,873	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	995,676	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)	325	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,464.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	475,872	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	885,749	2,429,146	0.364634	475,872	173,519	90.00
91.00	Nursing School cost	0	2,429,146	0.000000	475,872	0	91.00
92.00	Allied health cost	0	2,429,146	0.000000	475,872	0	92.00
93.00	All other Medical Education	0	2,429,146	0.000000	475,872	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,659	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,334	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	746	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	6	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	288	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	283	15.00
16.00	Nursery days (title V or XIX only)	179	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,524,777	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)	1,093,338	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,431,439	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,431,439	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,465.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	422,096	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)	422,096	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	310,729	283	1,097.98	179	196,538	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	618,634	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)	124,759	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)	124,759	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	493,875	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	325	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,465.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	476,323	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/19/2014 8:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	885,749	2,431,439	0.364290	476,323	173,520	90.00
91.00	Nursing School cost	0	2,431,439	0.000000	476,323	0	91.00
92.00	Allied health cost	0	2,431,439	0.000000	476,323	0	92.00
93.00	All other Medical Education	0	2,431,439	0.000000	476,323	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		765,096		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.513400	119,884	61,548	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.342399	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.436162	73,475	32,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261953	405,976	106,347	54.00
56.00	05600	RADIOISOTOPE	0.287508	21,783	6,263	56.00
60.00	06000	LABORATORY	0.207698	313,859	65,188	60.00
60.02	06002	GEO PSYCH	0.660515	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728939	28,273	20,609	62.00
65.00	06500	RESPIRATORY THERAPY	0.669755	104,206	69,792	65.00
66.00	06600	PHYSICAL THERAPY	0.528991	40,071	21,197	66.00
69.00	06900	ELECTROCARDIOLOGY	0.388738	20,473	7,959	69.00
69.01	06901	PULMONARY REHAB	0.852231	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780387	300,108	234,200	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597094	22,191	13,250	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637459	201,350	128,352	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.197857	35	42	90.00
91.00	09100	EMERGENCY	1.286468	1,232	1,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672421	2,329	1,566	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.906197	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,655,245	769,945	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)		1,655,245		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.513400	1,094	562	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.342399	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.436162	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261953	58,091	15,217	54.00
56.00	05600	RADIOISOTOPE	0.287508	0	0	56.00
60.00	06000	LABORATORY	0.207698	95,133	19,759	60.00
60.02	06002	GEO PSYCH	0.660515	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.728939	1,654	1,206	62.00
65.00	06500	RESPIRATORY THERAPY	0.669755	66,350	44,438	65.00
66.00	06600	PHYSICAL THERAPY	0.528991	177,847	94,079	66.00
69.00	06900	ELECTROCARDIOLOGY	0.388738	990	385	69.00
69.01	06901	PULMONARY REHAB	0.852231	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780387	82,345	64,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597094	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.637459	82,345	52,492	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.197857	0	0	90.00
91.00	09100	EMERGENCY	1.286468	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.672421	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04042	DIABETIC EDUCATION	2.906197	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		565,849	292,399	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)		565,849		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/19/2014 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,260,334	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,260,334	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,302,937	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)	37,330	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,322,911	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,942,696	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,942,696	30.00
31.00	Primary payer payments	1,371	31.00
32.00	Subtotal (line 30 minus line 31)	2,941,325	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)	229,240	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	201,731	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	214,151	36.00
37.00	Subtotal (see instructions)	3,143,056	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,143,056	40.00
40.01	Sequestration adjustment (see instructions)	62,861	40.01
41.00	Interim payments	2,999,214	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	80,981	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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,327,289		3,228,031	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	06/18/2014	433,808		0	3.01
3.02		03/03/2014	13,718		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	06/18/2014	228,817	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)		447,526		-228,817	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)		1,774,815		2,999,214	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		80,981	6.01
6.02	SETTLEMENT TO PROGRAM		117,900		0	6.02
7.00	Total Medicare program liability (see instructions)		1,656,915		3,080,195	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/19/2014 8:22 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,067,438		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	06/18/2014	189,357		0	3.01
3.02		03/03/2014	25,235		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		214,592		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)		1,282,030		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,850		0	6.02
7.00	Total Medicare program liability (see instructions)		1,266,180		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141305	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/19/2014 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	495	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	743	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	77	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,334	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	33,015,847	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	782,858	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141305 Component CCN: 14Z305	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/19/2014 8:22 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,005,633	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)	295,323	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	680	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)	1,300,956	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,300,956	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)	1,300,956	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,936	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)	1,292,020	0	15.00
16.00		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)	1,292,020	0	19.00
19.01	Sequestration adjustment (see instructions)	25,840	0	19.01
20.00	Interim payments	1,282,030	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	-15,850	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/19/2014 8:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,857,868	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)	1,857,868	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,876,447	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)	1,876,447	19.00
20.00	Deductibles (exclude professional component)	210,976	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,665,471	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,665,471	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,703	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,259	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,247	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,690,730	28.00
29.00		0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,690,730	30.00
30.01	Sequestration adjustment (see instructions)	33,815	30.01
31.00	Interim payments	1,774,815	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	-117,900	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: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/19/2014 8:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,062,760	0	0	0	1.00
2.00	Temporary investments	87,607	0	0	0	2.00
3.00	Notes receivable	34,679	0	0	0	3.00
4.00	Accounts receivable	3,686,921	0	0	0	4.00
5.00	Other receivable	464,472	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-780,000	0	0	0	6.00
7.00	Inventory	284,686	0	0	0	7.00
8.00	Prepaid expenses	111,046	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)	8,952,171	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	521,757	0	0	0	12.00
13.00	Land improvements	361,273	0	0	0	13.00
14.00	Accumulated depreciation	-196,277	0	0	0	14.00
15.00	Buildings	24,764,258	0	0	0	15.00
16.00	Accumulated depreciation	-8,229,147	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,556,711	0	0	0	23.00
24.00	Accumulated depreciation	-4,054,370	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,720,552	0	0	0	27.00
28.00	Accumulated depreciation	-1,529,836	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)	18,914,921	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	9,363,969	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	1,698,350	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,062,319	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,929,411	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	975,853	0	0	0	37.00
38.00	Salaries, wages, and fees payable	574,738	0	0	0	38.00
39.00	Payroll taxes payable	157,432	0	0	0	39.00
40.00	Notes and loans payable (short term)	566,322	0	0	0	40.00
41.00	Deferred income	32,064	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	383,301	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,689,710	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	18,848,291	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,848,291	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	21,538,001	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	17,391,410				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)	17,391,410	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,929,411	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/19/2014 8:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,414,418		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		646,799				2.00
3.00	Total (sum of line 1 and line 2)		17,061,217		0		3.00
4.00	CONTRIBUTIONS AND GRANTS FOR LONG	330,193		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)		330,193		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,391,410		0		11.00
12.00		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)		17,391,410		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CONTRIBUTIONS AND GRANTS FOR LONG		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			0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/19/2014 8:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,218,083		2,218,083	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,218,083		2,218,083	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,218,083		2,218,083	17.00
18.00	Ancillary services	4,834,127	0	4,834,127	18.00
19.00	Outpatient services	0	29,073,683	29,073,683	19.00
20.00	RURAL HEALTH CLINIC	0	2,291,340	2,291,340	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	241,449	241,449	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,052,210	31,606,472	38,658,682	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,299,972		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,299,972		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141305 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-3 | Date/Time Prepared: 11/19/2014 8:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,658,682	1.00
2.00	Less contractual allowances and discounts on patients' accounts	17,575,737	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,082,945	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,299,972	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,217,027	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	9,156	6.00
7.00	Income from investments	673,228	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	2,886	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	38,006	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	3,032	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	46,873	22.00
23.00	Governmental appropriations	50,642	23.00
24.00	HOSPITAL OTHER INCOME	27,652	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	76,338	24.01
24.02	NURSING HOME OTHER INCOME	192,220	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	0	24.03
24.04	GAIN ON DISPOSAL	913	24.04
24.05	SALARY REIMBURSEMENTS	50,654	24.05
24.06	EHR INCENTIVE	692,226	24.06
25.00	Total other income (sum of lines 6-24)	1,863,826	25.00
26.00	Total (line 5 plus line 25)	646,799	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	646,799	29.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/19/2014 8:22 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	341,872	0	341,872	-85,468	256,404	1.00
2.00	Physician Assistant	296,073	0	296,073	-10,101	285,972	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	199,256	0	199,256	0	199,256	9.00
10.00	Subtotal (sum of lines 1-9)	837,201	0	837,201	-95,569	741,632	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	149,831	149,831	0	149,831	12.00
13.00	Other Costs Under Agreement	0	7,173	7,173	0	7,173	13.00
14.00	Subtotal (sum of lines 11-13)	0	157,004	157,004	0	157,004	14.00
15.00	Medical Supplies	0	125,062	125,062	0	125,062	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	2,560	2,560	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	50,496	50,496	0	50,496	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	175,558	175,558	2,560	178,118	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	837,201	332,562	1,169,763	-93,009	1,076,754	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	120,044	120,044	0	120,044	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	120,044	120,044	0	120,044	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	837,201	452,606	1,289,807	-93,009	1,196,798	32.00

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/19/2014 8:22 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	256,404		1.00
2.00	Physician Assistant	0	285,972		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	199,256		9.00
10.00	Subtotal (sum of lines 1-9)	0	741,632		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	149,831		12.00
13.00	Other Costs Under Agreement	0	7,173		13.00
14.00	Subtotal (sum of lines 11-13)	0	157,004		14.00
15.00	Medical Supplies	0	125,062		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	2,560		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	50,496		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	178,118		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,076,754		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-45,197	74,847		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-45,197	74,847		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-45,197	1,151,601		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141305 Component CCN: 143456

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

Worksheet M-2

Date/Time Prepared: 11/19/2014 8:22 am

Rural Health Clinic (RHC) I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.75	2,341	4,200	3,150		1.00
2.00	Physician Assistant	2.00	5,465	2,100	4,200		2.00
3.00	Nurse Practitioner	0.90	2,072	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1-3)	3.65	9,878		9,240	9,878	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)	3.65	9,878			9,878	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)					1,076,754	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,076,754	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					74,847	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					514,393	15.00
16.00	Total overhead (sum of lines 14 and 15)					589,240	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					589,240	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					589,240	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,665,994	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/19/2014 8:22 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,665,994	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,404	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,659,590	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,878	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,878	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		168.01	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)	168.01	168.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,127	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	189,347	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) *		189,347	16.00
16.01	Total program charges (see instructions)(from contractor's records)		221,369	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		44,405	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		37,982	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.)		107,426	16.04
16.05	Total program cost (see instructions)		145,408	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,082	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		31,976	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		145,408	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,830	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		147,238	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00			0	25.00
26.00	Net reimbursable amount (see instructions)		147,238	26.00
26.01	Sequestration adjustment (see instructions)		2,945	26.01
27.00	Interim payments		139,292	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		5,001	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-4 | Date/Time Prepared: 11/19/2014 8:22 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	741,632	741,632	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000167	0.001753	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	124	1,300	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,025	1,690	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,149	2,990	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,076,754	1,076,754	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	589,240	589,240	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001067	0.002777	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	629	1,636	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,778	4,626	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	16	167	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	111.13	27.70	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	46	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	556	1,274	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)		6,404	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,830	16.00

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-5 | Date/Time Prepared: 11/19/2014 8:22 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		120,795	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		06/18/2014	3,659	3.01
3.02		03/03/2014	14,838	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		18,497	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		139,292	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		5,001	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		144,293	7.00

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