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: 141308	Period: From 05/01/2013 To 04/30/2014	Worksheet S Parts I-III Date/Time Prepared: 9/25/2014 4:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2014 Time: 4:24 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 WASHINGTON COUNTY HOSPITAL (141308) for the cost reporting period beginning 05/01/2013 and ending 04/30/2014 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	38,707	74,727	-9,406	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	41,572	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		56,389		0	10.00
200.00	Total	0	80,279	131,116	-9,406	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 705 SOUTH GRAND AVENUE	PO Box:			1.00
2.00	City: NASHVILLE	State: IL	Zip Code: 62263	County: WASHINGTON	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	WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	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	WASHINTON COUNTY EXTENDED CARE								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	GRAND STREET RHC	143470	99914		08/01/2005	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2013	04/30/2014	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2014 3:09 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2014 3:09 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 9/25/2014 3:09 pm

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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.	N	N	N	N	109.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	11,730	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141308	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part I Date/Time Prepared: 9/25/2014 3:09 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	140,925	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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 9/25/2014 3:09 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/01/2014	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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2014 3:09 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		ELAINE	MATZENBACHER		41.00
42.00	Enter the employer/company name of the cost report preparer.		WASHINGTON COUNTY HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		618-327-2207	EMATZENBACHER@WASHINGTONCOUNTYHOSPIT		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 9/25/2014 3:09 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/01/2014			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.		CFO		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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 9/25/2014 3:09 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	10,892.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	10,892.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	10,892.00	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	28	10,220			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					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)		50				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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	360	12	495			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,261	0	1,276			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	185			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,621	12	1,956			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,621	12	1,956	0.00	103.02	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			9,740	0.00	16.79	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	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)	1,860	0	6,101	0.00	10.21	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	130.02	27.00
28.00	Observation Bed Days		0	22			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	113	5	140	1.00
2.00	HMO and other (see instructions)			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	113	5	140	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				11	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					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: 141308 Component CCN: 143470 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-8 | Date/Time Prepared: 9/25/2014 3:09 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	705 SOUTH GRAND AVE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	NASHVILLE	IL	62263	2.00

			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	19:00	07:30	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	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	OKAWVILLE RHC	143470	14.00
14.01		GRAND STREET RHC	143472	14.01

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

			County				
			4.00				
2.00	City, State, Zip Code, County		WASHINGTON				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141308 Component CCN: 143470	Period: From 05/01/2013 To 04/30/2014	Worksheet S-8 Date/Time Prepared: 9/25/2014 3:09 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet S-10 | Date/Time Prepared: 9/25/2014 3:09 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.612524	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,374,612	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,799,275	6.00
7.00	Medicaid cost (line 1 times line 6)	1,102,099	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	119,558	11,085	130,643	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	73,232	6,790	80,022	21.00
22.00	Partial payment by patients approved for charity care	1,635	360	1,995	22.00
23.00	Cost of charity care (line 21 minus line 22)	71,597	6,430	78,027	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)	574,353	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	115,300	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	459,053	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	281,181	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	359,208	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	359,208	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		252,797	252,797	80,826	333,623	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		461,123	461,123	0	461,123	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,862	1,888,264	1,965,126	0	1,965,126	4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,000,493	761,031	1,761,524	-1,694	1,759,830	5.02
6.00	00600	MAINTENANCE & REPAIRS	121,028	386,686	507,714	0	507,714	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,063	73,063	0	73,063	8.00
9.00	00900	HOUSEKEEPING	197,057	23,804	220,861	0	220,861	9.00
10.00	01000	DIETARY	211,740	122,648	334,388	-31,466	302,922	10.00
11.00	01100	CAFETERIA	0	0	0	31,466	31,466	11.00
13.00	01300	NURSING ADMINISTRATION	74,255	77	74,332	0	74,332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,781	104,564	153,345	-94,766	58,579	14.00
15.00	01500	PHARMACY	122,639	570,010	692,649	-534,966	157,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	147,651	39,924	187,575	0	187,575	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,044	5,044	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	204,455	0	204,455	26,000	230,455	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	621,278	33,257	654,535	-5,044	649,491	30.00
46.00	04600	OTHER LONG TERM CARE	528,529	24,395	552,924	0	552,924	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	199,000	77,053	276,053	0	276,053	50.00
53.00	05300	ANESTHESIOLOGY	0	41,954	41,954	-26,000	15,954	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,457	136,486	372,943	47,559	420,502	54.00
57.00	05700	CT SCAN	55,055	83,940	138,995	0	138,995	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	65,908	65,908	0	65,908	58.00
60.00	06000	LABORATORY	348,763	527,060	875,823	0	875,823	60.00
65.00	06500	RESPIRATORY THERAPY	37,644	53,092	90,736	0	90,736	65.00
66.00	06600	PHYSICAL THERAPY	726,447	36,046	762,493	0	762,493	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	29,446	1,810	31,256	0	31,256	68.01
69.00	06900	ELECTROCARDIOLOGY	6,484	9,174	15,658	0	15,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	86,422	86,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,344	8,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	534,966	534,966	73.00
76.00	03480	ONCOLOGY	1,186	562	1,748	0	1,748	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	939,920	212,484	1,152,404	-45,865	1,106,539	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	314,865	1,157,859	1,472,724	0	1,472,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		83,302	83,302	-83,302	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,250,035	7,228,373	13,478,408	-2,476	13,475,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,134	4,134	2,476	6,610	190.00
190.01	19001	OUTPATIENT CLINIC	1,438	4,590	6,028	0	6,028	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	6,251,473	7,237,097	13,488,570	0	13,488,570	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	333,623		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-268,430	192,693		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-26,733	1,938,393		4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-18,066	1,741,764		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	507,714		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,063		8.00
9.00	00900	HOUSEKEEPING	0	220,861		9.00
10.00	01000	DIETARY	0	302,922		10.00
11.00	01100	CAFETERIA	-3,878	27,588		11.00
13.00	01300	NURSING ADMINISTRATION	0	74,332		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,161	56,418		14.00
15.00	01500	PHARMACY	0	157,683		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,707	185,868		16.00
17.00	01700	SOCIAL SERVICE	0	5,044		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	230,455		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	649,491		30.00
46.00	04600	OTHER LONG TERM CARE	0	552,924		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	276,053		50.00
53.00	05300	ANESTHESIOLOGY	0	15,954		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,146	414,356		54.00
57.00	05700	CT SCAN	0	138,995		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	65,908		58.00
60.00	06000	LABORATORY	-1,977	873,846		60.00
65.00	06500	RESPIRATORY THERAPY	0	90,736		65.00
66.00	06600	PHYSICAL THERAPY	0	762,493		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	31,256		68.01
69.00	06900	ELECTROCARDIOLOGY	-8,362	7,296		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	86,422		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,344		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	534,966		73.00
76.00	03480	ONCOLOGY	0	1,748		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-125,294	981,245		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-198,507	1,274,217		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-661,261	12,814,671		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,610		190.00
190.01	19001	OUTPATIENT CLINIC	0	6,028		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-661,261	12,827,309		200.00

RECLASSIFICATIONS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-6 | Date/Time Prepared: 9/25/2014 3:09 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	534,966		1.00
	TOTALS		0	534,966		
	B - RECLASSIFY MEDICAL SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	94,766		1.00
	TOTALS		0	94,766		
	C - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	19,925	11,541		1.00
	TOTALS		19,925	11,541		
	D - RECLASS SOCIAL SERVICE COST					
1.00	SOCIAL SERVICE	17.00	5,044	0		1.00
	TOTALS		5,044	0		
	E - RECLASS PROFESSIONAL LIABILITY INSUR					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	50,865		1.00
	TOTALS		0	50,865		
	F - RECLASSIFY XRAY DIRECTORS SALARY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	47,559	0		1.00
	TOTALS		47,559	0		
	H - RECLASSIFY ANESTHESIA PRO FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	26,000		1.00
	TOTALS		0	26,000		
	I - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	83,302		1.00
	TOTALS		0	83,302		
	J - TO RECLASS INTEROCULAR LENS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,344		1.00
	TOTALS		0	8,344		
	K - TO RECLASS THRIFT SHOP BLDG DEPREC					
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,476		1.00
	TOTALS		0	2,476		
	L - RECLASS SALARIES FOR A-8 RHC OFFSET					
1.00	RURAL HEALTH CLINIC	88.00	0	122,786		1.00
	TOTALS		0	122,786		
	M - TO RCLS PHYS RECRUIT EXP FOR CLINIC					
1.00	RURAL HEALTH CLINIC	88.00	0	5,000		1.00
	TOTALS		0	5,000		
500.00	Grand Total: Increases		72,528	940,046		500.00

RECLASSIFICATIONS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-6 | Date/Time Prepared: 9/25/2014 3:09 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY DRUG COSTS						
1.00	PHARMACY	15.00	0	534,966	0		1.00
	TOTALS		0	534,966			
	B - RECLASSIFY MEDICAL SUPPLY COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	94,766	0		1.00
	TOTALS		0	94,766			
	C - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	19,925	11,541	0		1.00
	TOTALS		19,925	11,541			
	D - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	5,044	0	0		1.00
	TOTALS		5,044	0			
	E - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC	88.00	0	50,865	0		1.00
	TOTALS		0	50,865			
	F - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	47,559	0	0		1.00
	TOTALS		47,559	0			
	H - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	26,000	0		1.00
	TOTALS		0	26,000			
	I - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	83,302	9		1.00
	TOTALS		0	83,302			
	J - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,344	0		1.00
	TOTALS		0	8,344			
	K - TO RECLASS THRIFT SHOP BLDG DEPREC						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,476	9		1.00
	TOTALS		0	2,476			
	L - RECLASS SALARIES FOR A-8 RHC OFFSET						
1.00	RURAL HEALTH CLINIC	88.00	122,786	0	0		1.00
	TOTALS		122,786	0			
	M - TO RCLS PHYS RECRUIT EXP FOR CLINIC						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	5,000	0		1.00
	TOTALS		0	5,000			
500.00	Grand Total: Decreases		195,314	817,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0	0	0	0	1.00
2.00	Land Improvements	372,843	0	0	0	2	2.00
3.00	Buildings and Fixtures	9,020,994	376,172	0	376,172	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	6,536,867	625,556	0	625,556	647,031	6.00
7.00	HIT designated Assets	720,944	138,652	0	138,652	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,714,503	1,140,380	0	1,140,380	647,033	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,714,503	1,140,380	0	1,140,380	647,033	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	62,855	0	1.00
2.00	Land Improvements	372,841	0	2.00
3.00	Buildings and Fixtures	9,397,166	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,515,392	0	6.00
7.00	HIT designated Assets	859,596	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,207,850	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,207,850	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 9/25/2014 3:09 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	252,797	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	461,123	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	713,920	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	252,797		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	461,123		2.00
3.00	Total (sum of lines 1-2)	0	713,920		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 9/25/2014 3:09 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	9,832,862	0	9,832,862	0.571417	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,374,988	0	7,374,988	0.428583	0	2.00
3.00	Total (sum of lines 1-2)	17,207,850	0	17,207,850	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	333,623	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	192,693	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	526,316	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	333,623	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	192,693	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	526,316	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8 | Date/Time Prepared: 9/25/2014 3:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-15,301	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,161	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-211,986			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,029	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-3,878	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	-1,707	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-267,868	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS REVENUE	B	292	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8 | Date/Time Prepared: 9/25/2014 3:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01			0		0.00	0	33.01
34.00	LAB FEES	A	-1,977	LABORATORY	60.00	0	34.00
35.00	EDUCATION FEES	B	-350	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-15,818	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	33,963	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-13,758	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	NON-RHC SERVICES	A	-125,294	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-26,733	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	TELEPHONE SERVICE	B	-7,094	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00	NON-RHC DEPRECIATION	A	-562	CAP REL COSTS-MVBLE EQUIP	2.00	9	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-661,261				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 9/25/2014 3:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	40	40	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	5,077	5,077	0	0	0	2.00
3.00	60.00	LABORATORY	20,009	0	20,009	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	8,362	8,362	0	0	0	4.00
5.00	91.00	EMERGENCY	1,136,271	198,507	937,764	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,169,759	211,986	957,773		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	40		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,077		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,362		4.00
5.00	91.00	EMERGENCY	0	0	0	198,507		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	211,986		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	333,623	333,623				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	192,693		192,693			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,938,393	609	0	1,939,002		4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,741,764	75,205	0	305,317	2,122,286	5.02
6.00	00600	MAINTENANCE & REPAIRS	507,714	53,034	6,661	38,777	606,186	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,063	4,181	0	0	77,244	8.00
9.00	00900	HOUSEKEEPING	220,861	1,915	0	63,137	285,913	9.00
10.00	01000	DIETARY	302,922	7,845	570	61,458	372,795	10.00
11.00	01100	CAFETERIA	27,588	3,853	0	6,384	37,825	11.00
13.00	01300	NURSING ADMINISTRATION	74,332	609	0	23,791	98,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,418	3,507	6,748	15,629	82,302	14.00
15.00	01500	PHARMACY	157,683	4,292	14,554	39,294	215,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	185,868	4,495	71	47,307	237,741	16.00
17.00	01700	SOCIAL SERVICE	5,044	406	0	1,616	7,066	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	230,455	0	0	65,507	295,962	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	649,491	29,600	7,977	197,441	884,509	30.00
46.00	04600	OTHER LONG TERM CARE	552,924	42,138	2,261	169,341	766,664	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	276,053	15,594	46,890	63,760	402,297	50.00
53.00	05300	ANESTHESIOLOGY	15,954	0	1,866	0	17,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	414,356	20,656	17,367	90,999	543,378	54.00
57.00	05700	CT SCAN	138,995	0	63,225	17,640	219,860	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65,908	0	0	0	65,908	58.00
60.00	06000	LABORATORY	873,846	9,313	10,706	111,744	1,005,609	60.00
65.00	06500	RESPIRATORY THERAPY	90,736	2,197	2,720	12,061	107,714	65.00
66.00	06600	PHYSICAL THERAPY	762,493	9,105	894	232,754	1,005,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	31,256	1,943	240	9,434	42,873	68.01
69.00	06900	ELECTROCARDIOLOGY	7,296	268	0	2,077	9,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	86,422	0	0	0	86,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,344	0	0	0	8,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	534,966	0	0	0	534,966	73.00
76.00	03480	ONCOLOGY	1,748	1,094	53	380	3,275	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	981,245	11,126	675	261,810	1,254,856	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,274,217	15,903	7,184	100,883	1,398,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,814,671	318,888	190,662	1,938,541	12,797,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,610	1,126	0	0	7,736	190.00
190.01	19001	OUTPATIENT CLINIC	6,028	13,609	2,031	461	22,129	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,827,309	333,623	192,693	1,939,002	12,827,309	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.02	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	2,122,286					5.02
6.00	00600	MAINTENANCE & REPAIRS	120,177	726,363				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,314	14,831	107,389			8.00
9.00	00900	HOUSEKEEPING	56,683	6,793	0	349,389		9.00
10.00	01000	DIETARY	73,907	27,828	0	13,796	488,326	10.00
11.00	01100	CAFETERIA	7,499	13,669	0	6,776	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,574	2,161	0	1,071	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,316	12,441	0	6,168	0	14.00
15.00	01500	PHARMACY	42,787	15,224	0	7,547	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,132	15,944	0	7,905	0	16.00
17.00	01700	SOCIAL SERVICE	1,401	1,441	0	714	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	58,675	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	175,355	104,994	13,498	52,053	87,088	30.00
46.00	04600	OTHER LONG TERM CARE	151,992	149,467	71,366	74,104	398,923	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,756	55,312	2,803	27,422	0	50.00
53.00	05300	ANESTHESIOLOGY	3,533	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,725	73,270	3,876	36,325	0	54.00
57.00	05700	CT SCAN	43,587	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,066	0	0	0	0	58.00
60.00	06000	LABORATORY	199,363	33,034	0	16,377	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,354	7,792	75	3,863	0	65.00
66.00	06600	PHYSICAL THERAPY	199,291	32,297	9,902	16,012	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	8,500	6,892	0	3,417	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,911	949	0	471	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,133	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,654	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	106,058	0	0	0	0	73.00
76.00	03480	ONCOLOGY	649	3,880	0	1,923	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	248,776	39,467	248	19,566	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	277,197	56,409	5,301	27,966	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,116,365	674,095	107,069	323,476	486,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,534	3,994	0	1,980	0	190.00
190.01	19001	OUTPATIENT CLINIC	4,387	48,274	320	23,933	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	2,315	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,122,286	726,363	107,389	349,389	488,326	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	65,769					11.00
13.00	01300	NURSING ADMINISTRATION	755	122,293				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,121	0	118,348			14.00
15.00	01500	PHARMACY	841	0	115	282,337		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,106	0	71	0	311,899	16.00
17.00	01700	SOCIAL SERVICE	778	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,710	47,749	15,393	158	18,239	30.00
46.00	04600	OTHER LONG TERM CARE	13,067	0	17,184	0	18,260	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,709	10,398	8,133	3	25,354	50.00
53.00	05300	ANESTHESIOLOGY	778	0	3,157	139	1,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,868	0	1,260	236	26,442	54.00
57.00	05700	CT SCAN	778	0	609	0	38,603	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	248	0	6,360	58.00
60.00	06000	LABORATORY	6,001	0	3,229	63	67,660	60.00
65.00	06500	RESPIRATORY THERAPY	802	3,772	1,275	0	5,366	65.00
66.00	06600	PHYSICAL THERAPY	8,927	0	1,540	626	36,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	638	0	1,126	0	2,165	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	67	0	3,127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	36,811	0	1,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,866	0	314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	280,965	31,258	73.00
76.00	03480	ONCOLOGY	23	0	406	0	862	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,947	37,462	1,991	0	10,397	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,616	22,912	16,781	147	18,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	109	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,574	122,293	118,262	282,337	311,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	195	0	86	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	65,769	122,293	118,348	282,337	311,899	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part I | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	11,400					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	354,637				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,260	0	1,418,006	-47,313	1,370,693	30.00
46.00	04600	OTHER LONG TERM CARE	1,140	0	1,662,167	0	1,662,167	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	614,187	0	614,187	50.00
53.00	05300	ANESTHESIOLOGY	0	354,637	381,399	0	381,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	796,380	0	796,380	54.00
57.00	05700	CT SCAN	0	0	303,437	0	303,437	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	85,582	0	85,582	58.00
60.00	06000	LABORATORY	0	0	1,331,336	0	1,331,336	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	152,013	0	152,013	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,310,022	0	1,310,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	65,611	0	65,611	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	16,166	0	16,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	141,965	0	141,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,178	0	19,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	953,247	0	953,247	73.00
76.00	03480	ONCOLOGY	0	0	11,018	0	11,018	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,620,710	0	1,620,710	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	1,827,893	0	1,827,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	109	47,313	47,422	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,400	354,637	12,710,426	0	12,710,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,244	0	15,244	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	99,324	0	99,324	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	2,315	0	2,315	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,400	354,637	12,827,309	0	12,827,309	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	609	0	609	609	4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	75,205	0	75,205	94	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	53,034	6,661	59,695	12	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,181	0	4,181	0	8.00
9.00	00900	HOUSEKEEPING	0	1,915	0	1,915	20	9.00
10.00	01000	DIETARY	0	7,845	570	8,415	19	10.00
11.00	01100	CAFETERIA	0	3,853	0	3,853	2	11.00
13.00	01300	NURSING ADMINISTRATION	0	609	0	609	7	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,507	6,748	10,255	5	14.00
15.00	01500	PHARMACY	0	4,292	14,554	18,846	12	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,495	71	4,566	15	16.00
17.00	01700	SOCIAL SERVICE	0	406	0	406	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	21	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,600	7,977	37,577	62	30.00
46.00	04600	OTHER LONG TERM CARE	0	42,138	2,261	44,399	53	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,594	46,890	62,484	20	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,866	1,866	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,656	17,367	38,023	29	54.00
57.00	05700	CT SCAN	0	0	63,225	63,225	6	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	9,313	10,706	20,019	35	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,197	2,720	4,917	4	65.00
66.00	06600	PHYSICAL THERAPY	0	9,105	894	9,999	73	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	1,943	240	2,183	3	68.01
69.00	06900	ELECTROCARDIOLOGY	0	268	0	268	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	1,094	53	1,147	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,126	675	11,801	83	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	15,903	7,184	23,087	32	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	318,888	190,662	509,550	609	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,126	0	1,126	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	13,609	2,031	15,640	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	333,623	192,693	526,316	609	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.02	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	75,299					5.02
6.00	00600	MAINTENANCE & REPAIRS	4,264	63,971				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	543	1,306	6,030			8.00
9.00	00900	HOUSEKEEPING	2,011	598	0	4,544		9.00
10.00	01000	DIETARY	2,622	2,451	0	179	13,686	10.00
11.00	01100	CAFETERIA	266	1,204	0	88	0	11.00
13.00	01300	NURSING ADMINISTRATION	694	190	0	14	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	579	1,096	0	80	0	14.00
15.00	01500	PHARMACY	1,518	1,341	0	98	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,672	1,404	0	103	0	16.00
17.00	01700	SOCIAL SERVICE	50	127	0	9	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,082	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,222	9,247	758	677	2,441	30.00
46.00	04600	OTHER LONG TERM CARE	5,393	13,164	4,007	966	11,180	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,830	4,871	157	357	0	50.00
53.00	05300	ANESTHESIOLOGY	125	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,822	6,453	218	472	0	54.00
57.00	05700	CT SCAN	1,546	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	464	0	0	0	0	58.00
60.00	06000	LABORATORY	7,073	2,909	0	213	0	60.00
65.00	06500	RESPIRATORY THERAPY	758	686	4	50	0	65.00
66.00	06600	PHYSICAL THERAPY	7,071	2,844	556	208	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	302	607	0	44	0	68.01
69.00	06900	ELECTROCARDIOLOGY	68	84	0	6	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	608	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,763	0	0	0	0	73.00
76.00	03480	ONCOLOGY	23	342	0	25	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,827	3,476	14	254	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,834	4,968	298	364	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,089	59,368	6,012	4,207	13,621	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	352	0	26	0	190.00
190.01	19001	OUTPATIENT CLINIC	156	4,251	18	311	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	65	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	75,299	63,971	6,030	4,544	13,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	5,413					11.00
13.00	01300	NURSING ADMINISTRATION	62	1,576				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92	0	12,107			14.00
15.00	01500	PHARMACY	69	0	12	21,896		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	256	0	7	0	8,023	16.00
17.00	01700	SOCIAL SERVICE	64	0	0	0	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	717	615	1,575	12	470	30.00
46.00	04600	OTHER LONG TERM CARE	1,075	0	1,758	0	470	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	223	134	832	0	653	50.00
53.00	05300	ANESTHESIOLOGY	64	0	323	11	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	318	0	129	18	681	54.00
57.00	05700	CT SCAN	64	0	62	0	994	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	25	0	164	58.00
60.00	06000	LABORATORY	494	0	330	5	1,733	60.00
65.00	06500	RESPIRATORY THERAPY	66	49	130	0	138	65.00
66.00	06600	PHYSICAL THERAPY	735	0	158	49	932	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	53	0	115	0	56	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	7	0	81	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,765	0	41	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	907	0	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,790	805	73.00
76.00	03480	ONCOLOGY	2	0	42	0	22	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	654	483	204	0	268	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	380	295	1,717	11	473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	9	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,397	1,576	12,098	21,896	8,023	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	16	0	9	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,413	1,576	12,107	21,896	8,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B Part II | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	657					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,103				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	591		60,964	0	60,964	30.00
46.00	04600	OTHER LONG TERM CARE	66		82,531	0	82,531	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		72,561	0	72,561	50.00
53.00	05300	ANESTHESIOLOGY	0		2,423	0	2,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		50,163	0	50,163	54.00
57.00	05700	CT SCAN	0		65,897	0	65,897	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		653	0	653	58.00
60.00	06000	LABORATORY	0		32,811	0	32,811	60.00
65.00	06500	RESPIRATORY THERAPY	0		6,802	0	6,802	65.00
66.00	06600	PHYSICAL THERAPY	0		22,625	0	22,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
68.01	06801	CARDIAC REHAB	0		3,363	0	3,363	68.01
69.00	06900	ELECTROCARDIOLOGY	0		515	0	515	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		4,414	0	4,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		974	0	974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		26,358	0	26,358	73.00
76.00	03480	ONCOLOGY	0		1,603	0	1,603	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		26,064	0	26,064	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	0		41,459	0	41,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		9	0	9	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	657	0	502,189	0	502,189	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1,558	0	1,558	190.00
190.01	19001	OUTPATIENT CLINIC	0		20,401	0	20,401	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0		65	0	65	190.02
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		2,103	2,103	0	2,103	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	657	2,103	526,316	0	526,316	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.02	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,293					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		212,877				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	6,051,825			4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	16,296	0	952,934	-2,122,286	10,705,023	5.02
6.00	00600	MAINTENANCE & REPAIRS	11,492	7,359	121,028	0	606,186	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	0	0	0	77,244	8.00
9.00	00900	HOUSEKEEPING	415	0	197,057	0	285,913	9.00
10.00	01000	DIETARY	1,700	630	191,815	0	372,795	10.00
11.00	01100	CAFETERIA	835	0	19,925	0	37,825	11.00
13.00	01300	NURSING ADMINISTRATION	132	0	74,255	0	98,732	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	760	7,455	48,781	0	82,302	14.00
15.00	01500	PHARMACY	930	16,078	122,639	0	215,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	974	78	147,651	0	237,741	16.00
17.00	01700	SOCIAL SERVICE	88	0	5,044	0	7,066	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	204,455	0	295,962	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,414	8,813	616,234	0	884,509	30.00
46.00	04600	OTHER LONG TERM CARE	9,131	2,498	528,529	0	766,664	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,379	51,802	199,000	0	402,297	50.00
53.00	05300	ANESTHESIOLOGY	0	2,062	0	0	17,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,476	19,186	284,016	0	543,378	54.00
57.00	05700	CT SCAN	0	69,847	55,055	0	219,860	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	65,908	58.00
60.00	06000	LABORATORY	2,018	11,827	348,763	0	1,005,609	60.00
65.00	06500	RESPIRATORY THERAPY	476	3,005	37,644	0	107,714	65.00
66.00	06600	PHYSICAL THERAPY	1,973	988	726,447	0	1,005,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	421	265	29,446	0	42,873	68.01
69.00	06900	ELECTROCARDIOLOGY	58	0	6,484	0	9,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	86,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	534,966	73.00
76.00	03480	ONCOLOGY	237	58	1,186	0	3,275	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,411	746	817,134	0	1,254,856	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,446	7,936	314,865	0	1,398,187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,100	210,633	6,050,387	-2,122,286	10,675,158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244	0	0	0	7,736	190.00
190.01	19001	OUTPATIENT CLINIC	2,949	2,244	1,438	0	22,129	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	333,623	192,693	1,939,002		2,122,286	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.614873	0.905185	0.320400		0.198251	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			609		75,299	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000101		0.007034	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS	44,373					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	34,218				8.00
9.00	00900	HOUSEKEEPING	415	0	43,052			9.00
10.00	01000	DIETARY	1,700	0	1,700	38,595		10.00
11.00	01100	CAFETERIA	835	0	835	0	8,450	11.00
13.00	01300	NURSING ADMINISTRATION	132	0	132	0	97	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	760	0	760	0	144	14.00
15.00	01500	PHARMACY	930	0	930	0	108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	974	0	974	0	399	16.00
17.00	01700	SOCIAL SERVICE	88	0	88	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,414	4,301	6,414	6,883	1,119	30.00
46.00	04600	OTHER LONG TERM CARE	9,131	22,740	9,131	31,529	1,679	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,379	893	3,379	0	348	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,476	1,235	4,476	0	497	54.00
57.00	05700	CT SCAN	0	0	0	0	100	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,018	0	2,018	0	771	60.00
65.00	06500	RESPIRATORY THERAPY	476	24	476	0	103	65.00
66.00	06600	PHYSICAL THERAPY	1,973	3,155	1,973	0	1,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	421	0	421	0	82	68.01
69.00	06900	ELECTROCARDIOLOGY	58	0	58	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	237	0	237	0	3	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,411	79	2,411	0	1,021	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,446	1,689	3,446	0	593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	14	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,180	34,116	39,859	38,412	8,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244	0	244	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	2,949	102	2,949	0	25	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	183	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	726,363	107,389	349,389	488,326	65,769	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.369481	3.138377	8.115511	12.652572	7.783314	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,971	6,030	4,544	13,686	5,413	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.441665	0.176223	0.105547	0.354606	0.640592	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	55,760					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	111,381				14.00
15.00	01500	PHARMACY	0	108	537,359			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67	0	20,750,902		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,771	14,487	300	1,213,439	90	30.00
46.00	04600	OTHER LONG TERM CARE	0	16,172	0	1,214,795	10	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,741	7,654	6	1,686,762	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,971	265	88,832	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,186	449	1,759,186	0	54.00
57.00	05700	CT SCAN	0	573	0	2,568,252	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	233	0	423,102	0	58.00
60.00	06000	LABORATORY	0	3,039	120	4,501,865	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,720	1,200	0	356,972	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,449	1,191	2,407,102	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	1,060	0	144,051	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	63	0	208,043	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34,645	0	106,403	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,344	0	20,869	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	534,748	2,079,577	0	73.00
76.00	03480	ONCOLOGY	0	382	0	57,345	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,081	1,874	0	691,726	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,447	15,793	280	1,222,581	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,760	111,300	537,359	20,750,902	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	81	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	122,293	118,348	282,337	311,899	11,400	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.193203	1.062551	0.525416	0.015031	114.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,576	12,107	21,896	8,023	657	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.028264	0.108699	0.040747	0.000387	6.570000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-1 | Date/Time Prepared: 9/25/2014 3:09 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
68.01	06801	CARDIAC REHAB	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03480	ONCOLOGY	0	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	190.02
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	354,637	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,546.370000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,103	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	21.030000	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet B-2 | Date/Time Prepared: 9/25/2014 3:09 pm

		Description	Worksheet Part	Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS AND PEDIATRICS	1	30.00	-47,313	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	47,313	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,370,693		1,370,693	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,662,167		1,662,167	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614,187		614,187	0	0	50.00
53.00	05300	ANESTHESIOLOGY	381,399		381,399	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,380		796,380	0	0	54.00
57.00	05700	CT SCAN	303,437		303,437	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85,582		85,582	0	0	58.00
60.00	06000	LABORATORY	1,331,336		1,331,336	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	152,013	0	152,013	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,310,022	0	1,310,022	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	65,611	0	65,611	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	16,166		16,166	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,965		141,965	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,178		19,178	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	953,247		953,247	0	0	73.00
76.00	03480	ONCOLOGY	11,018		11,018	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,620,710		1,620,710	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,827,893		1,827,893	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,530		16,530		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	47,422		47,422	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	12,726,956	0	12,726,956	0	0	200.00
201.00		Less Observation Beds	16,530		16,530		0	201.00
202.00		Total (see instructions)	12,710,426	0	12,710,426	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	751,772		751,772			30.00
46.00	04600	OTHER LONG TERM CARE	1,214,795		1,214,795			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,530	1,672,232	1,686,762	0.364122	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,874	85,958	88,832	4.293487	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,264	1,705,922	1,759,186	0.452698	0.000000	54.00
57.00	05700	CT SCAN	69,963	2,498,289	2,568,252	0.118149	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,443	416,659	423,102	0.202273	0.000000	58.00
60.00	06000	LABORATORY	279,356	4,222,509	4,501,865	0.295730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	180,859	176,113	356,972	0.425840	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	347,575	2,059,527	2,407,102	0.544232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	144,051	144,051	0.455471	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	10,421	197,622	208,043	0.077705	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,473	89,930	106,403	1.334220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,869	20,869	0.918971	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	441,198	1,638,379	2,079,577	0.458385	0.000000	73.00
76.00	03480	ONCOLOGY	0	57,345	57,345	0.192135	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	691,726	691,726			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,000	1,219,581	1,222,581	1.495110	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	18,082	18,082	0.914169	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	24,969	418,616	443,585	0.106906	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	3,417,492	17,333,410	20,750,902			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,417,492	17,333,410	20,750,902			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,370,693		1,370,693	0	1,370,693	30.00
46.00	04600	OTHER LONG TERM CARE	1,662,167		1,662,167	0	1,662,167	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	614,187		614,187	0	614,187	50.00
53.00	05300	ANESTHESIOLOGY	381,399		381,399	0	381,399	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,380		796,380	0	796,380	54.00
57.00	05700	CT SCAN	303,437		303,437	0	303,437	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	85,582		85,582	0	85,582	58.00
60.00	06000	LABORATORY	1,331,336		1,331,336	0	1,331,336	60.00
65.00	06500	RESPIRATORY THERAPY	152,013	0	152,013	0	152,013	65.00
66.00	06600	PHYSICAL THERAPY	1,310,022	0	1,310,022	0	1,310,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	65,611	0	65,611	0	65,611	68.01
69.00	06900	ELECTROCARDIOLOGY	16,166		16,166	0	16,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	141,965		141,965	0	141,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,178		19,178	0	19,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	953,247		953,247	0	953,247	73.00
76.00	03480	ONCOLOGY	11,018		11,018	0	11,018	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,620,710		1,620,710	0	1,620,710	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,827,893		1,827,893	0	1,827,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,530		16,530		16,530	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	47,422		47,422	0	47,422	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	12,726,956	0	12,726,956	0	12,726,956	200.00
201.00		Less Observation Beds	16,530		16,530		16,530	201.00
202.00		Total (see instructions)	12,710,426	0	12,710,426	0	12,710,426	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	751,772		751,772			30.00
46.00	04600	OTHER LONG TERM CARE	1,214,795		1,214,795			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,530	1,672,232	1,686,762	0.364122	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,874	85,958	88,832	4.293487	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,264	1,705,922	1,759,186	0.452698	0.000000	54.00
57.00	05700	CT SCAN	69,963	2,498,289	2,568,252	0.118149	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,443	416,659	423,102	0.202273	0.000000	58.00
60.00	06000	LABORATORY	279,356	4,222,509	4,501,865	0.295730	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	180,859	176,113	356,972	0.425840	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	347,575	2,059,527	2,407,102	0.544232	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	144,051	144,051	0.455471	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	10,421	197,622	208,043	0.077705	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,473	89,930	106,403	1.334220	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,869	20,869	0.918971	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	441,198	1,638,379	2,079,577	0.458385	0.000000	73.00
76.00	03480	ONCOLOGY	0	57,345	57,345	0.192135	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	691,726	691,726	2.342994	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	3,000	1,219,581	1,222,581	1.495110	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	18,082	18,082	0.914169	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	24,969	418,616	443,585	0.106906	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	3,417,492	17,333,410	20,750,902			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,417,492	17,333,410	20,750,902			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet C Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part II Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,561	1,686,762	0.043018	4,791	206	50.00
53.00	05300	ANESTHESIOLOGY	2,423	88,832	0.027276	2,874	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,163	1,759,186	0.028515	28,846	823	54.00
57.00	05700	CT SCAN	65,897	2,568,252	0.025658	34,127	876	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	653	423,102	0.001543	3,057	5	58.00
60.00	06000	LABORATORY	32,811	4,501,865	0.007288	123,541	900	60.00
65.00	06500	RESPIRATORY THERAPY	6,802	356,972	0.019055	45,840	873	65.00
66.00	06600	PHYSICAL THERAPY	22,625	2,407,102	0.009399	16,515	155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	3,363	144,051	0.023346	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	515	208,043	0.002475	5,363	13	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,414	106,403	0.041484	3,596	149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	974	20,869	0.046672	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,358	2,079,577	0.012675	127,598	1,617	73.00
76.00	03480	ONCOLOGY	1,603	57,345	0.027954	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,064	691,726	0.037680	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	41,459	1,222,581	0.033911	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,594	18,082	0.143458	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	9	443,585	0.000020	11,755	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	361,288	18,784,335		407,903	5,695	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	354,637	0	0	0	354,637	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	354,637	0	0	0	354,637	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,686,762	0.000000	0.000000	4,791	50.00
53.00	05300	ANESTHESIOLOGY	0	88,832	3.992221	0.000000	2,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,759,186	0.000000	0.000000	28,846	54.00
57.00	05700	CT SCAN	0	2,568,252	0.000000	0.000000	34,127	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	423,102	0.000000	0.000000	3,057	58.00
60.00	06000	LABORATORY	0	4,501,865	0.000000	0.000000	123,541	60.00
65.00	06500	RESPIRATORY THERAPY	0	356,972	0.000000	0.000000	45,840	65.00
66.00	06600	PHYSICAL THERAPY	0	2,407,102	0.000000	0.000000	16,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
68.01	06801	CARDIAC REHAB	0	144,051	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	208,043	0.000000	0.000000	5,363	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	106,403	0.000000	0.000000	3,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,869	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,079,577	0.000000	0.000000	127,598	73.00
76.00	03480	ONCOLOGY	0	57,345	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	691,726	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,222,581	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	18,082	0.000000	0.000000	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	443,585	0.000000	0.000000	11,755	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	18,784,335			407,903	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part IV | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	11,474	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.00	03480	ONCOLOGY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	11,474	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.364122	0	778,162	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4.293487	0	40,258	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452698	0	698,441	0	0	54.00
57.00	05700	CT SCAN	0.118149	0	968,220	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.202273	0	137,012	0	0	58.00
60.00	06000	LABORATORY	0.295730	0	1,791,644	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.425840	0	63,784	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.544232	0	693,670	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.455471	0	99,595	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.077705	0	111,292	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.334220	0	43,274	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918971	0	15,652	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458385	0	1,087,044	1,041	0	73.00
76.00	03480	ONCOLOGY	0.192135	0	23,325	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.495110	0	418,416	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914169	0	13,307	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.106906	0	232,526	1,791	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	7,215,622	2,832	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	7,215,622	2,832	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	283,346	0		50.00
53.00	05300	ANESTHESIOLOGY	172,847	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,183	0		54.00
57.00	05700	CT SCAN	114,394	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,714	0		58.00
60.00	06000	LABORATORY	529,843	0		60.00
65.00	06500	RESPIRATORY THERAPY	27,162	0		65.00
66.00	06600	PHYSICAL THERAPY	377,517	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	45,363	0		68.01
69.00	06900	ELECTROCARDIOLOGY	8,648	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,737	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,384	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	498,285	477		73.00
76.00	03480	ONCOLOGY	4,482	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	625,578	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	12,165	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	24,858	191		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,140,506	668		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,140,506	668		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308 | Component CCN: 14Z308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.364122	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4.293487	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452698	0	0	0	0	54.00
57.00	05700	CT SCAN	0.118149	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.202273	0	0	0	0	58.00
60.00	06000	LABORATORY	0.295730	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.425840	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.544232	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.455471	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.077705	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.334220	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918971	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458385	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.192135	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.495110	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914169	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.106906	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
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: 141308 | Component CCN: 14Z308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D Part V | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,978	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	517	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)	495	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	788	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)	488	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	70	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)	115	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	360	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)	788	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)	473	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	124.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	128.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,370,693	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)	8,727	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)	14,771	25.00
26.00	Total swing-bed cost (see instructions)	982,233	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	388,460	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)	388,460	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)	751.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	270,490	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)	270,490	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	161,798	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	432,288	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)	592,072	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	355,393	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	947,465	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)	22	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	751.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	16,530	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-1 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	60,964	388,460	0.156938	16,530	2,594	90.00
91.00	Nursing School cost	0	388,460	0.000000	16,530	0	91.00
92.00	Allied health cost	0	388,460	0.000000	16,530	0	92.00
93.00	All other Medical Education	0	388,460	0.000000	16,530	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-3 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		289,230		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.364122	4,791	1,745	50.00
53.00	05300	ANESTHESIOLOGY	4.293487	2,874	12,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452698	28,846	13,059	54.00
57.00	05700	CT SCAN	0.118149	34,127	4,032	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.202273	3,057	618	58.00
60.00	06000	LABORATORY	0.295730	123,541	36,535	60.00
65.00	06500	RESPIRATORY THERAPY	0.425840	45,840	19,521	65.00
66.00	06600	PHYSICAL THERAPY	0.544232	16,515	8,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	0.455471	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.077705	5,363	417	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.334220	3,596	4,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918971	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458385	127,598	58,489	73.00
76.00	03480	ONCOLOGY	0.192135	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.495110	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914169	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.106906	11,755	1,257	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		407,903	161,798	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)		407,903		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet D-3

Component CCN: 14Z308 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.364122	2,563	933	50.00
53.00	05300	ANESTHESIOLOGY	4.293487	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452698	14,755	6,680	54.00
57.00	05700	CT SCAN	0.118149	10,619	1,255	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.202273	0	0	58.00
60.00	06000	LABORATORY	0.295730	108,289	32,024	60.00
65.00	06500	RESPIRATORY THERAPY	0.425840	92,811	39,523	65.00
66.00	06600	PHYSICAL THERAPY	0.544232	308,224	167,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	0.455471	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.077705	2,422	188	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.334220	7,482	9,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918971	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.458385	255,209	116,984	73.00
76.00	03480	ONCOLOGY	0.192135	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.495110	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.914169	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.106906	5,327	569	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		807,701	375,884	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)		807,701		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E Part B Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,141,174	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)	3,141,174	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)	3,172,586	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	17,912	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,093,311	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)	2,061,363	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)	2,061,363	30.00
31.00	Primary payer payments	131	31.00
32.00	Subtotal (line 30 minus line 31)	2,061,232	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)	115,914	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	102,004	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,752	36.00
37.00	Subtotal (see instructions)	2,163,236	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,163,236	40.00
40.01	Sequestration adjustment (see instructions)	43,265	40.01
41.00	Interim payments	2,045,244	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	74,727	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		310,602		1,994,527	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	04/30/2014	80,782	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/18/2014	7,066		0	3.50
3.51		11/20/2013	12,611	11/20/2013	30,065	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)		-19,677		50,717	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)		290,925		2,045,244	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		38,707		74,727	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		329,632		2,119,971	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: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 9/25/2014 3:09 pm

Component CCN: 14Z308 | 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		1,259,407		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/20/2013	28,066		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)		-28,066		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)		1,231,341		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		41,572		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,272,913		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: 141308	Period: From 05/01/2013 To 04/30/2014	Worksheet E-1 Part II Date/Time Prepared: 9/25/2014 3:09 pm
	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	140	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	360	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	495	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	20,750,902	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	130,643	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	140,925	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	131,328	8.00
9.00	Sequestration adjustment amount (see instructions)	2,627	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	128,701	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	138,107	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)	-9,406	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141308 | Component CCN: 14Z308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet E-2 | Date/Time Prepared: 9/25/2014 3:09 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	956,940	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)	379,643	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	1,261	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)	1,336,583	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,336,583	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)	1,336,583	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	37,692	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)	1,298,891	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,298,891	0	19.00
19.01	Sequestration adjustment (see instructions)	25,978	0	19.01
20.00	Interim payments	1,231,341	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	41,572	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: 141308	Period: From 05/01/2013 To 04/30/2014	Worksheet E-3 Part V Date/Time Prepared: 9/25/2014 3:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	432,288	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)	432,288	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	436,611	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	436,611	19.00
20.00	Deductibles (exclude professional component)	106,240	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	330,371	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	330,371	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,805	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,988	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	336,359	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	336,359	30.00
30.01	Sequestration adjustment (see instructions)	6,727	30.01
31.00	Interim payments	290,925	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	38,707	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G | Date/Time Prepared: 9/25/2014 3:09 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	851,268	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,417,800	0	0	0	4.00
5.00	Other receivable	43,268	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-425,000	0	0	0	6.00
7.00	Inventory	286,147	0	0	0	7.00
8.00	Prepaid expenses	108,614	0	0	0	8.00
9.00	Other current assets	118,174	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,400,271	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	372,841	0	0	0	13.00
14.00	Accumulated depreciation	-358,533	0	0	0	14.00
15.00	Buildings	9,397,166	0	0	0	15.00
16.00	Accumulated depreciation	-6,790,101	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	6,515,392	0	0	0	23.00
24.00	Accumulated depreciation	-5,565,960	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	859,596	0	0	0	27.00
28.00	Accumulated depreciation	-578,610	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)	3,914,646	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,267,336	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,267,336	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,582,253	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	259,137	0	0	0	37.00
38.00	Salaries, wages, and fees payable	574,820	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	229,502	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	588,994	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,652,453	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,897,485	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	1,897,485	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,549,938	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,032,315				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)	5,032,315	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,582,253	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G-1 | Date/Time Prepared: 9/25/2014 3:09 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,558,907		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		473,408				2.00
3.00	Total (sum of line 1 and line 2)		5,032,315		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,032,315		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,032,315		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/25/2014 3:09 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	384,860		384,860	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	366,912		366,912	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	1,214,795		1,214,795	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,966,567		1,966,567	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,966,567		1,966,567	17.00
18.00	Ancillary services	1,495,383	16,921,107	18,416,490	18.00
19.00	Outpatient services	0	443,585	443,585	19.00
20.00	RURAL HEALTH CLINIC	0	1,148,821	1,148,821	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.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,461,950	18,513,513	21,975,463	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,488,570		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,488,570		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141308	Period: From 05/01/2013 To 04/30/2014	Worksheet G-3 Date/Time Prepared: 9/25/2014 3:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	21,975,463	1.00
2.00	Less contractual allowances and discounts on patients' accounts	8,922,080	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,053,383	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,488,570	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-435,187	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	19,537	6.00
7.00	Income from investments	21,936	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	2,011	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	13,256	22.00
23.00	Governmental appropriations	354,268	23.00
24.00	GRANT INCOME	290,905	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	187,631	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	477	24.02
24.03	OTHER MISCELLANEOUS INCOME	18,574	24.03
25.00	Total other income (sum of lines 6-24)	908,595	25.00
26.00	Total (line 5 plus line 25)	473,408	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	473,408	29.00

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

Provider CCN: 141308 Component CCN: 143470 | Period: From 05/01/2013 To 04/30/2014 | Worksheet M-1 | Date/Time Prepared: 9/25/2014 3:09 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	939,920	0	939,920	0	939,920	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	939,920	0	939,920	0	939,920	10.00
11.00	Physician Services Under Agreement	0	140,190	140,190	0	140,190	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	4,425	4,425	0	4,425	13.00
14.00	Subtotal (sum of lines 11-13)	0	144,615	144,615	0	144,615	14.00
15.00	Medical Supplies	0	3,727	3,727	0	3,727	15.00
16.00	Transportation (Health Care Staff)	0	2,140	2,140	0	2,140	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	50,865	50,865	-50,865	0	18.00
19.00	Other Health Care Costs	0	0	0	5,000	5,000	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	56,732	56,732	-45,865	10,867	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	939,920	201,347	1,141,267	-45,865	1,095,402	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	3,126	3,126	0	3,126	29.00
30.00	Administrative Costs	0	8,011	8,011	0	8,011	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	11,137	11,137	0	11,137	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	939,920	212,484	1,152,404	-45,865	1,106,539	32.00

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

Provider CCN: 141308 Component CCN: 143470 | Period: From 05/01/2013 To 04/30/2014 | Worksheet M-1 | Date/Time Prepared: 9/25/2014 3:09 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-122,786	817,134		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	-122,786	817,134		10.00
11.00	Physician Services Under Agreement	0	140,190		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	4,425		13.00
14.00	Subtotal (sum of lines 11-13)	0	144,615		14.00
15.00	Medical Supplies	-214	3,513		15.00
16.00	Transportation (Health Care Staff)	-386	1,754		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	5,000		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	-600	10,267		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-123,386	972,016		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	-1,908	1,218		29.00
30.00	Administrative Costs	0	8,011		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,908	9,229		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-125,294	981,245		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141308 | Period: From 05/01/2013 To 04/30/2014 | Worksheet M-2

Component CCN: 143470 | Date/Time Prepared: 9/25/2014 3:09 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.55	4,151	4,200	6,510		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.74	1,950	2,100	1,554		3.00
4.00	Subtotal (sum of lines 1-3)	2.29	6,101		8,064	8,064	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)	2.29	6,101			8,064	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)					972,016	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)					972,016	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)					9,229	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					639,465	15.00
16.00	Total overhead (sum of lines 14 and 15)					648,694	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					648,694	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					648,694	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,620,710	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141308 Component CCN: 143470	Period: From 05/01/2013 To 04/30/2014	Worksheet M-3 Date/Time Prepared: 9/25/2014 3:09 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,620,710	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,159	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,616,551	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		8,064	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)		8,064	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		200.47	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)	200.47	200.47	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,860	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	372,874	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) *		372,874	16.00
16.01	Total program charges (see instructions)(from contractor's records)		225,422	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		277,943	16.04
16.05	Total program cost (see instructions)		277,943	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,445	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,995	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		277,943	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,038	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		279,981	22.00
23.00	Allowable bad debts (see instructions)		8,305	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		7,308	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,305	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		287,289	26.00
26.01	Sequestration adjustment (see instructions)		5,746	26.01
27.00	Interim payments		225,154	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		56,389	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: 141308 | Component CCN: 143470 | Period: From 05/01/2013 To 04/30/2014 | Worksheet M-4 | Date/Time Prepared: 9/25/2014 3:09 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	817,134	817,134	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000347	0.001175	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	284	960	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	779	471	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,063	1,431	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	972,016	972,016	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	648,694	648,694	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001094	0.001472	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	710	955	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,773	2,386	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	13	44	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	136.38	54.23	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	25	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	682	1,356	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)		4,159	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)		2,038	16.00

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

Provider CCN: 141308 Component CCN: 143470 | Period: From 05/01/2013 To 04/30/2014 | Worksheet M-5 | Date/Time Prepared: 9/25/2014 3:09 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		249,336	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		04/18/2014	6,018	3.50
3.51		11/20/2013	18,164	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)		-24,182	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		225,154	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		56,389	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		281,543	7.00

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